Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MINNIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore DALTIMON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 💢 F 71 215-30-9681 Dec. 26, 1935 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Baltimore Nottingham Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 U.S.A. 23 Bridle Lane items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. the Medical Examiner 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 1 ☐ Yes 2 No White Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, nt of Health and Mental Hy
If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alphonse Guarino Minnie Souza Pages 1 and 2 should P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Bridle Lane, Nottingham, MD 21236 Gloria Lynn Bean (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2007 Parkville, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underthin Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 1□ Yes 2-1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 | Yes 2 | No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) r 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

State Registrar MCE

31. Date filed (Month, Day, Year) FEB 2 8 2007

DHMH 17 Rev 1/2001

8800

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

w

32. Registrar's Signature

			For State Registrar	State of Mary	•		lealth and I	Mental Hy	giene Reg. No. 007	06002
	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last) Alvin Butterfield 4a. Facility Name (If not institution, give st Randolph Hills Nurs			4b. City, Town, or Wheaton	Location of Deat	2. Date of Dea Month 02	Day Yea 06 200 4c. County of De	07 11:05 p <sup>M</sup>
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		irthplace (State or Foreign Country) rmuda
	e Maryland ia-f show	ctor	10a. State 10b. County MD Montgomer		c. City, Town or Lo Vheaton					10d. Inside City Limits 1 ☐ Yes 2 X No
	sath with th	eral Dire	4011 Randolph Rd.	2. Was Decedent Ever	in U.S. 13 1	10f. Zip Code 20902	ispanic Origin? (S	pecify Yes or No	USA  14. Race - Ar	Country?
036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ite Modical Examiner must be notified at	d by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ★Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerl Specify:	o Rican, etc.)	Specify: b]	hite, etc. _ack&white
1215-0	within 72 ho iene. • than "natu	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Busines Self-Empl	
yland 2	ould be filed Mental Hyg arkad othar atic evant,	To Be C	17. Father's Name (First, Middle, Last) unknown				Theodor	a unknow		
re, Mar	Tand 2 sho Health and Iam 27 Is m		19a. Informant's Name/Relationship (Type Richard Butterfiel 20a. Method of Disposition	d/son	9158 Ob. Place of Dispo	Springhi esition (Name of	11 Ct. G		MD 2077 20c. Location - City	)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Itam 27 is marked other than "natural," or Items 23a or 28a-f show important: If Itam 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other traumatic event, It is Modical Examinating must be notified at once.		1 Burial 2 X Cremation 3 Re '4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		Chesapea	ke Cremat 2. Name and Addre	ory 3-3-	2007	Beltsville	
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the e cause on each line.	death. Do not ent	ter the mode of dyin	* Funera	TAIterr	natives To	Approximate Interval Batween Onset and Death
	/Medical Examiner  ysician and he burial-transit	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
.O. Box 68760,	The law requires that the death certificate be e tie has been signed by the attending physician page 2 should be detached for use as the burit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other (specify)	1		23d. Date of Month	delivery Day Year
Vital Records, P.	aw requires that as been signed b 2 should be deta	Completed by PI	Part II. Other significant conditions con Diabetes Mellitus		ot resulting in the u	inderlying cause giv	en in Part I.		Yes 2 No 3 an 24b. Were	o to the cause of death?  Probably 4 Munknown  autopsy findings available to completion of cause of
/ital Re	Physician: The larthis certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	ospital:		Ott		perfo 1 ☐ Yes ath (Check only o	ormed? death 2 No 1 □ Y one)	? es 2 No
of	Phy this ral d	ation; To	1 Yes 2 No	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury	of 28c. Injur	y at		dence 6 Other (S	pecify)
Division	fter fter in b	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)			City or To		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)  2 Medical Examinate of certifier (Check only one)	sician: To the best of more: On the basis of example and manner stated	amination and/or in	n occurred at the file expection, in my control	ppinion, death occ	urred at the time,	date and place, and of	lue to the cause(s)
•	4		30. Name and address of person who co	mpteted cause of death	n (Item 23a) (Type	7 D50			2-10-07	
	Sta Regist	ate rar	Alan R. Segal 1 31. Date filed (Month. Pay 8 2007	5) 7 Huge 32. Registrar's	Signature Co	Silver	Sprin	grad	20906	

			1 - For State Registrar	tate of Marylan		artment of Hertificate of L			jiene	007	060	03
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of D	eath
	Physici		AMELIA BRAWNEI	}				February	7 19.	2007	2036	М
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Dea	<u> </u>	<u> </u>	unty of Death	1	
	Examin	٠.	SOUTHERN MARYLAND	HOSPITAL		CLINTON			PRI	NCE GEO	ORGES	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) r 22	9. Birth Cou	place (State or I	Foreign
	D		Usual Residence of Decedent  10a, State 10b, County	100 Cit	y, Town or Lo	cation					10d. Inside City	Limita
	anyla ehov	-			y, TOWIT OF LO	Cation					1 Yes 2	
	Ba-f	ctc	Maryland Prince Geor	ges Suit	1and	1						
	or 2	ä	10e. Street and Number			10f. Zip Code		1	-	n of What Cou	intry?	
	ath v	<u>a</u>	Candy Apple Lane			20746				S. A.		
	er de	nue		Was Decedent Ever in U. Armed Forces?	.S.   13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Amer Black, White		
36	rs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ≦ No If Yes, Give Year or Dates:		1 ☐ Yes 2 Ho	Specify:		Sp	pecify: B]	LACK	
ခို	within 72 hours after death with the Maryland ene. Then "neturel", or items 23e or 28e-f ehow te Mudical Ezantiner must be notified a	ed t	15. Decedent's Educati		16a Deced	dent's Usual Occupa	ition		16h Kind	of Business/Ir	ndustry	
5	in 72	olet	(Specify only highest grade co	mpleted)	(Give	kind of work done di DO NOT use retired)	u <i>rina</i> most of wo	orking	100.11470	0. 500034	idustry	
21215-0036	the end	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Secre	tarv			Cove	rnment		
<u> </u>	filed ther other ont,	BeC	17. Father's Name (First, Middle, Last)		DOCTO	,	18. Mother's Na	ıme (First, Middle,				
Maryland	d benta	ToB	Bernard Loving				Bob Ell	a Durant				
a Z	shour and M and M umat	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street a	nd Number or R	lural Route Number	r, City or To	own, State, Zi	p Code)	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene.  Importment if them 27 is marked other than "neturel; or items 23a or 28a-1 show eny injury or other traumatic event, it a Hudical Examinar ment be notified at ORGE.		Stephen J. Brawner-	Husband	Candy	Apple La	ne 4145	Suitlar	nd, Ma	aryland	1 20746	
Baltimore,	of He		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	9)	Date	20c. Local	tion - City or T	own, State	
Ë	Page ento nt:∺ ryor		ty☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Jvai iiuiii State		lemorial		28-2007	Suit	land. N	MARYLANI	0
<b>#</b>	mit.		21. Signature of Funeral Service Licens	/		. Name and Address					MICLERIA	
ñ	Depa Impo eny in		- Krith-O. A.	- Main		38 Marlbo					nd 20747	7
			23a. Pert1. Enter the disease, or complicate shock, or heart failure. List only one of	of that caused the death							Approximate	
	Physician		Immediate Cause (Final								Interval Betwee Onset and De	
}	/Medical		disease or condition resulting in death)	Due to (or as a consequence								
	Examiner			Brease	<u>'</u>	1011						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ								
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o o	exec an an rial-tr	Ex	resulting in death) Last	Due to (or as a conseq	nce of):			_				
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89	nifica ng ph as th	Med	IE EELIN S									
ŏ	th cer endir r use	No.	230. Was decedent pregnant	If yes, outcome of pregna		Ectopic pregnancy			230	. Date of deliv	,	
P.O. Box	deal	by Physician/Med	in the past 12 months? 1 Pyes 2 No	4☐Pregnant at time of do		Other (specify)				Month	Day Ye	ar
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Division of Vital Records, I	Attending Physician: The law requires that the death certificate be executed refeath.  r death.  ector: Alter this certificate hes been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.		Part II. Other significant conditions contrib	uting to death but not rest	ulting in the u	nderlying cause give	n in Part I.		bacco use es 2□N		the cause of dea bably 4 XUni	
္ပ	s bee	Completed						24a. Wasa		24b. Were aut	opsy findings av	ailable
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ta	an: tiffice tor, p	Be C	25. Was case referred to medical				26. Place of De	1 Yes		1 🗆 Yes	230 110	
<u> </u>	ysici is cer direc	0	examiner? 1 ☐ Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 🗙	ER/Outpatien	t 3 DOA Othe	-	Home 5 ☐ Reside		Other (Speci	fv)	
0	g Ph er th berai	Į.	27. Manner of Death	8a. Date of Injury (Month, Day Year)	28b. Time of Injury		at	28d. Describe h	<del></del>		-77	
<u>o</u>	ndin ath. r: Aft e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, Day 1 Gar)	injury		r res 2 □No					
<u>X</u>	Atte	iii	3 ☐ Suicide 6 ☐ Could not be determined	8e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (Si City or Town		lumber or Rur	al Route Numbe	er,
ā	s efter or	Certification:	4 Trainings	bulldarig, etc. (Opecin)	"			Only of Your	i, State)			
	To the Hospital or Attending Physician: The law within 24 buous effer death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier Certifying Physicial (Check only 2 Medical Examiner:	an: To the best of my kno On the basis of examina	wledge, death	occurred at the time	e, date and plac	e, and due to the c	ause(s) an	d manner as	stated.	
	the H in 24 the F plete	Medicai	one)	and manner stated.	tion and/or in	vestigation, in my op	minon, death occ	urred at the time, d	ate and pia	ace, and due t	to the cause(s)	
	To T	Σ	29b. Signature and title of certifier			29c. License				igned (Month,		
			hoons	$\bigcirc$		h 00 (	94055	>	0.5	19/	1	
	1		30. Name and address of person who comp Eric McDonald, MD				ryland	20735				
	Sta	te	31. Date filed (Month, Day, Year)	20 Deintraria Signa	tura		-					
	Registr	ar	FEB 2 7 200	32. Hagistrar's Signa	1. M	DUALL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Brown Mary Feb 21 2007 2200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE **GEORGES** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 28 9. Birthplace (State or Foreign Country) Florida 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 81 Director 267-32-1740 Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other thaumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Director Prince Georges Suitland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Keir Drive 3404 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistical Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Will Ryan Cora Cohen ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora L. Rose - Daughter Keir Drive 3404 Suitland Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 02-28-07 Clinton Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Home P.A. 21. Signature of uneral Service License 5538 Marlboro Pike Forestville Maryland 20747 · MUIUST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dunity (or as a consequence of) Examiner the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **∂** BREMT CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital ... within 24 hours after death.
To the Funeral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

Division or Vital Records,

10

State

Registrar

31. Date filed (Month, Day, Year)

TORRY

29b. Signature and title of certifier

100 pt

JUDRLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



7503

SURRATTS READ, CLIWTON, MARY LAND 2073T

29c. License number

D40324

29d. Date signed (Month, Day, Year)

FEBRUARY 23, 2007

State of Maryland / Department of Health and Mental Hygiene 06005 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year **Physician** FEB. 26 12:08 AM MARJORIE LOUISE CISLO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER **BETHESDA** ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Days Hours New York Yrs 79 Director 117 20 3450 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes XXNo Directo Maryland Prince George's Brandvwine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 United States 14511 Becker Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after ☐Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ρ 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Cislo Marjorie Lorich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 673 Laurel Ave, Lititz, Pa 17543 Tom Cislo (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) March 1, Dat 2007 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if iten
eny injury or ott 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cemetery Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandrîa Ferry Rd, Clinton, MD 20735 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cluse. Entail Underlying Cause (Disease or injury Due to (or as a consequence of) ner certificate be executed inding physician and use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? etter 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 TNo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 2 No 1 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the 2 Accident Director 6 Could not be determined To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 0101236904 -2/26/2007 NATIONAL NAVAL MEDICAL CE TER **1**5 30. Name and address of per property impleted cause of death (Item 23a) (Type, Print) MC\_USN 52. Registrar's Signature BETHESDA MD 20889-5600 DAVID M. YOU LT31. Date filed (Month, Day, Year) FEB 2 8 2 State Registrar

	_1	State Registrar	of Marylan		artment of H rtificate of L	ealth and M Death		Reg. No.	2007	06006
Physicia		Decedent's Name (First, Middle, Last)	. (	Don.	Ner		2. Date of Dea	Day	Year	3. Time of Death
/Medica	1	a. Facility Name (If not institution, give street and nu		-010.		Location of Death	pen		County of Death	3017
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Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug 8	h y, Year)	Cour	lace (State or Foreign
Director	_	216-48-9989 1	61	Yrs.			Aug 8 1	945	Mary	länd
land ow	-	0a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
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th the	Directo	0e. Street and Number			10f. Zip Code			10g. Citi	zen of What Coun	try?
tier death with the Marylan free thems 23a or 28a-f show in at must be notified at	<u>a</u>	1016 Twin View			_1	060			SA	
er de:	runerai	Armed F		.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	.	<ol> <li>Race - Americ Black, White.</li> </ol>	
5-UU36 72 hours after death with the Maryland naturel, or Items 23e or 28e-f show alcul Ever in or most ten redified at	<u>ጉ</u>	1 ☐ Never Married 2 ☐ XMarried 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or D	ive '`		1□Yes 2□XNo	Specify:			SpecifyWhite	è
Ind 21215-UU36 be filed within 72 hours af tal Hygiene. d other then "naturel", or event, tre Hydical Ever	Completed	15. Decedent's Education (Specify only highest grade completed)	Maria Company	16a. Dece	dent's Usual Occupa	ation luring most of workir )	20	16b. Kir	nd of Business/Ind	lustry
ifthin and and and and and and and and and an	- Pie		1-4or 5+)			)	.9			
MG 2121 stiled within I Hygiene. other then rent, tre Mer	3	7. Father's Name (First, Middle, Last)		Homem	aker	18. Mother's Name	(First Middle	Maiden	Househol	d
	0 26	John Frank	Ne:	slein		Anna	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	May		Brown
Marylan d 2 should be th and Mental 7 is marked of treumatic eve		9a. Informant's Name/Relationship (Type, Print)			ng Address (Street a	and Number or Rura	l Route Numbe			
and 2 and 2 ealth a n 27 is	1	Charles G Conner			1016 Twin	View G1	en_Burn	ie.N	21060	
Baltimore, Dermit. Pages 1 a Department of Hes Important: If item any injury or otha	2	Oa. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		lace of Dispo	sition (Name of natory or other place	D	ate	20c. Lo	cation - City or To	wn, State
EIM Pag tment tant: jury c		* 4 □ Donation 5 □ Other (Specify)			ematory I		/07	Balt	imore Ma	ryland
Baltimore, N Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		21. Signature of Fyrantal Service Ucensee	/		. Name and Addres	Sta	llings	Fune	eral Home	P.A.
	+	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caus of the death	h. Do not ent	3111 Mount	tain Rd P	asadona	MD	21122	Approximate
Pnysician		shock, or heart failure. List only one cause on mmediate Cause (Final	each line	10		Heart	D	21 apr 2	n- 0.	Interval Between Onset and Death
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Examiner		Sequentially list conditions, b.	Lyper		5100					
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Of V Physic	0	examiner?  1. Yes 2 No Hospital: 1	Inpatient 2	ER/Outpatier	t 3□ DOA Othe	4 🗆 Nursing Hom	ne 5 🗆 Resid	lence 6	S □Other (Specify	)
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L or A after Dirac	Certification	4 Homicide determined 266. Flate build	ling, etc. (Specif)	y)	eer, ractory, onice	-	City or Ton	m, State)	)	House Humbor,
		29a. Certifier 1☐ Certifying Physician: To th								
To the H within 24 To the F complete	edical		ner stated.	tion and/or in						
To COLL	Σ	29b. Signature and title of certifier	$\longrightarrow D$	epil	fy 29c. License				e signed (Month, I	
	4	Julia K	No	mo	DIV		(	0	4/26	7
5		30. Name and address of person who completed on	se death (Item	1 23a) (Type,	0 69	0005 5 Ame	orin.	A	211	35
State	e	11. Date filed (Month Day Year) 7007 32	Registrar's Signa	furs Ing	de la	y spru	100		VII V	
Registra	r	5 mm 10 0 001		4						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 1150 AM SARAH OCK 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Baltimore <u>2731 Cylburn</u> Ave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1□M 2/□F Months Days Hours Min. Yrs 60 27 219-50-1725 FLUsual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 2731 Cylburn Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Story Teller Self Employed 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nita Lance Joseph Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2731 Cylburn Ave, Baltimore, Md Curnell Crockett-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 2/27/07 Randallstwon, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -und Lancer Mon Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify)

**Physician** /Medical Examiner

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To the Hospital or within 24 hours af To the Funeral D

page 2 should

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r than "natural", or Items 23a or 28a-f shorthe Medical Examiner must be notified at

within 72 hours after death with the Maryland

e filed within al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event

Maryland 21215-0036

Baltimore,

1 Yes 2 No 27. Manner of Death

1 ☑ Natural 2 ☐ Accident

3 Suicide

29b. Signature

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. EUT AW ST #305 · ANANIDA Kals HNAN

State Registrar 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year am <sup>M</sup> 0930 FEB. 2007 ANGELA DOOLEY CLARK 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCHESTER 6226 KNOLL HILL DR. BERLIN If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 212.36.3503 90 Vrs Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ₩No Directo WORCHESTER MD BERL IN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 e 23a or 6226 KNOLL HILL DR. USA 21811 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify. þ WHITE 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PSYCHIATRIC NURSE STATE OF MD 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ie marked ANNA CORCORAN MICHAEL DOOLEY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
important: If item 27 ie
eny injury or other trau 6226 KNOLL HILL DR., BERLIN, MD 21811 MICHAEL CLARK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEMETERY FEB. 24, 2007 BALTIMORE, MD 21. Signatur Fineral Service Licens

K GREGORY FINK 22. Name and Address of Facility
FINK FUNERAL HONE, P.A. M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknowh Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown should ! Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b lirector, page 2 si autopsy performed? Yes 20 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 🗌 Yes SAMO After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 3 🗀 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and mount as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 -20-07 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Philade 1001 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 27, 2007 **Physician** Hyerta 7:03 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 217-18-9786 91 Feb. 27, 1916 Director m Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore m 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1006 Kevin 21229 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ  $\lambda \alpha I/e \gamma$  AIVeV altimore, Maryland 21215-003 3 Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Aborer Manutactory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida McClendon James 0. Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Sylvia Smith Daughter

20a. Method of Disposition

1 Method of Disposition

1 Daughter

2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 1006 Kevin Rd. Balto., mD 21224
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3-3-2007 Baltimore, mi Woodlawn Cemetery 22. Name and Address of Froility
Vaughn C. Greene Funeral Services
5151 Baitimore Nat Pik Baito, mD 21229 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infaction **Physician** /Medical **Examiner** direare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit ancu Due to (or as a consequence of) Physician/Medical as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav signed by the a 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Melli certificate has been sirector, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 21/60116 Vancular 1ºernheral 1∐ Yes 2 100 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22/100 1 Tes ٩ 27. Manner of Death 28a. Date of Injury ospital or Attending Pinous after death.
Ineral Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ampaim SoPS 271201 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fixe Mirta MM, 6701 N-Charler St, Towson, MM 2120L; 3. Registrar's Signature 31. Date filed (Month, Day, Year)

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			For State Registrar	State of Maryland		rtment of He			ene 007	06010
			Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
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	/Medic		4a. Facility Name (If not institution, gi			4b. City, Town, or		unky a	4c. County of Deat	
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	Funeral			Sex 7. Age (In yrs. I.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		213-30-6957	1⊠M 2□F 76	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) July 21	[°1930 Mar	yland
			Usual Residence of Decedent							
	rylan how		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	e-f.	cto	MD Balti	more	Caton	sville				1 ☐ Yes 2 ☐ No
	or 28	lre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	puntry?
	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23e or 28e-f show ent, tre Medical Examinations to milited at	by Funeral Director	701 Edmondson Av	enue		21228			USA	
	r dea	ne	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	고	1 Never Married 2 Married	If Yes, Give	1	☐ Yes 2X No	Specify:		Specify: wh	ite
ĕ	ure!,		3 Widowed 4 Divorced	Year or Dates:						
<u>γ</u>	"nat	Completed	15. Decedent's I (Specify only highest g	rade completed)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of workin	g	6b. Kind of Business	andustry
Š	withir	g E	Elementary/Secondary (0-12)	College (1-4or 5+)	_					
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and	ntal hed of	Be	Tr. Fathor o Franco (Frior, Wildelo, East	"/		dik		(, , , , , , , , , , , , , , , , , , ,		unk
Maryland 21215-0036	hould d Me mark matic	၉	19a. Informant's Name/Relationship	(Type Print)	19h Mailin	o Address (Street a	and Number or Rural	Route Number	City or Town, State, a	Zin Code)
Za	d 2 s th an th an treu		Craig Gibson/care		1				MD 21620	
	1 an Heal em 2	1	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of	Da		Oc. Location - City or	
סַר	Pages nent of H ant: If Ite		1 Burial 2 Cremation 3	Hemoval from State	emetery, cren	natory`or other place	9)			
Baltimore,	it. Partme		'4 □ Donation 5 ☒ Other (Spec		22	Name and Addres	s of Facility			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other treumatic event, the Madical Exercitive Frank Experiment 2000.		21. Signature of Ronal Space Lice	Made, Director	1	ate Anato	my Board	655 W. 1	Baltimore	Street
			23a. Part 1 Enter the disease, or co	mplications that caused the death	h. Do not ente	Itimore,	MD 21201	respiratory arres	at.	Approximate
			shock, or heart failure. List on	ly one cause on each line.						Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	silero	re can	diovasu	lar o	'seese	10 Yrst
П	Examiner			Due to (or as a consequ	uence of):		diovasur Agitated	0 4		5 Yet
		-	Sequentially list conditions,	b. Due to (or as a consequ	uence ob.	0112	ag teres	- Post Ly	4	مرا ا
Т	ted nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, , ,	,					
	xecu al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	ate be executed thysician and the burial-transit	dical		d						
68		edic								
Вох	death certific e attending p ed for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
	death a atte	icla	in the past 12 months?	1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
o.	that the deled by the a	hys	9 □ Unknown	9□ Unknown						
Ψ,	s that ned t	by P	Part II. Other significant conditions	contributing to death but not resi	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ğ	w requires that been signed I should be det							1 🗆 Yes	2 <b>⊡√N</b> o 3 □ Pi	robably 4 □Unknown
00	s bee	olet						24a. Was an	24b. Were au	utopsy findings available
Re	The law requires that the rate has been signed by the page 2 should be detache	Completed				-		autopsy performe	ed? death?	completion of cause of 2□ No
of Vital Records,		Be C	25. Was case referred to medical				26. Place of Death			2010
>	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	ac .		ce 6 □Other (Spe	cify)
	tending Physicien: leath. tor: After this certific the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how	injury occurred	
Ö	Attending r death. ector: After by the fune	atlo	1		injury		res 2□No			
Division	or Attendated of the order of t	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, str	eet, factory, office	2	8f. Location (Stre	et and Number or Ri State)	ural Route Number,
Ö	s afte	Certification:		g, oto (open)	,,					
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by			Physician: To the best of my kno eminer: On the basis of examina						
	To the H within 24 To the F complete	Medical	one)	and manner stated.	Thorn direction in					
	Vith To	2	29b. Signature and title of certifier	Krzp /		29c. License			d. Date signed (Mont	n, Day, Year)
•				1, mg			031865		4/26/	
			30. Name and address of person wh		n 23a) (Type,				Root:	md 2/20/
			. Mier-Door Ki	rune m.o f	im 206	821	N. Enthu	street )	DEVINOR	md and
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature Loc	. D. a				
	Regist	ar	FEB 2 8 2	007 Bellepour St	CAN AS	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #29d, perMD, g864, 2/28/07 TT Certificate of Death Desedent's Name (First, Middle, Last) 2. Date of Death 15:24 PM **Physician** 200 chrany /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex If Under 24 Hrs **Funeral** Year) Days 1 ☑ M 2 ☐ F 216-24-8548 79 Nov. 4,1927 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 XNo ns 23a or 28a-f st must be notified Directo Maryland Dundalk Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 7824 Rockbourne Road United States or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) 12 Years Foreman Steel Industry is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Vincent Dowling Margaret Ellen Dougherty ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 7824 Rockbourne Road Dundalk, Maryland Mrs. Ellen Jane Dowling (Wife) 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2/ 22. Name and Address of Facility 2/19/2007 Baltimore, Maryland Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part — ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** umon urce /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 2 11 No Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

Day, Year,

FEB

31. Date filed (Mor

DHMH 17 Rev 1/2001

em Avenue

empleted cause of death (Item 23a) (Type, Print)

ar's Signature

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CHARLES EINOLF FEBRUARY 23 11:34 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b\_City, Town, or Location of Death 4c. County of Death Examiner RANDALISTOWN BALTIMORE 1ATI 920H NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1X M 2□ F 1918 Maryland 30, Sept 88 Director 215-07-1207 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code 21207 USA 6825 Campfield Rd. Bldg. 11 H-T death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 Xes 2 No
If Yes, Give
Year or Dates: 1944-46 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify.White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Technology Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ges 1 and 2 should be fill of Health and Mental H Wilhelmina Coleman Otto William Einolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6825 Campfield Rd. Bldg.11, H-T Baltimore, MD 21207 Dorothy F. Einolf/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: If i permit. Page Department o Important: If any injury or Chesapeake Crematory | 02/26/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 to Mo/25/ Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of) Examiner COLITIS PSEUDOMENBRANOUS Sequentially list conditions, it is a property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p for use as as IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 FAILURE RENAL icate has been siç , page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an certificate has autopsy 2 **2** No 1□ Yes rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 SNo ∩SInpatient 2 ER/Outpatient 3 □ DOA P After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 D54352 FEBRUARY 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30+1

State Registrar 31. Date filed (Month, Day, Year)

OBAZEE

M.D. 5401 32 Registrar's Signature

ORIGINAL

Old

Court Rd

RANDAILS FOUN, Mb

_			1- State of Maryland Department of Health and N Registrar #5 Per INF G865 3/09 Certificate of Death	Mental Hyg	iene 007	06013
	Physic	cian	1. Decedent's Name (First, Middle, Last)  To seph Flowers	2. Date of Deat Month	th Day Year	3. Time of Death
	/Med Exam		Joseph Flowers  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2	22 200=	
1	Exam	iner	Baltimore VA Medical Center Baltimore	2	4c. County of Dea	th
Ī	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent	11 07		ountry) NC
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-fs	Director	MD NA Baltimore			1 X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmust be rottfled at	Dire	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	ountry?
	death ms 23	Funeral	3618 Wabash Ave  21215  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Research)	anifu Van an Na	U.S.A	
ဖွ			Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	encan Indian, e, etc.
21215-0036	hours after tural', or Ite	d by	Year or Dates:		Specify: B	lack
15	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)  Flementary/Secondary (0.13)  College (1.45.5)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)  life. DO NOT use retired)	ing	16b. Kind of Business	Industry
212	be filed within a tal Hygiene. d other than "revent, the Med	Com	Elementary/Secondary (0-12) College (1-4or 5+)  12th grade 3yrs Steam Fitter		aryland	Devidoak
Maryland	be filed Ital Hygi Ital other	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, N	Maiden Sumame)	Drydock
ryla	2 should be and Mental Is marked craumatic even	J.	Isaih Flowers Ola Dur  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Burn			
	and 2 salth ar n 27 ls		The state of the s			
ore,	es 1 and 2 of Health fitem 27 I r other tre		20a. Method of Disposition 20b. Place of Disposition (Name of	altimor Date 2	e, Mo 2 20c. Location - City or	L2L5 Town, State
altimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other traumatic once.		'4□Donation 5□Other (Specify) Garrison Forest Vet 3/	/2/07	Owings M	ills, Md
Bal	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensed  22. Name and Address of Facility  March F/H West  4300 Wabash Ave.			
			shock, or heart failure. List only one cause on each line.	r respiratory arre	est,	Approximate Interval Between
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. DNEUMONIA			Onset and Death
	Examiner		que to (or as a consequence of):			
^	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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8760,	icate be executed physician and s the burial-transit	dicai E	Due to (or as a consequence of):			
9	tificate og phy. as the	ledic	d			
Вох	eath certifii attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	very
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		Month	Day Year
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Vital Records,	v requires been sign should be		coronary artery disease			obably 4 Unknown
ecc	e law re has be je 2 sho	Completed	diabetes mellitus	24a. Was an autopsy	24b. Were au	topsy findings available
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Vit		o Be	25. Was case referred to medical examiner?  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
of	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 Residen	nce 6 Other (Spec	ify)
sior	Attending in death.	atio	2 Accident Investigation M 1 Yes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
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1	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, dat	e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Month	
,	1.		20 Name and artifere of a series of a seri	1	ノーノン	LOUT
	H		Melissa Vant, M.D. P20876  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Melissa Vant, M.D. 10 North Greene Streen	et BALL	Emple Mi	12/20/
	Stat		32 (Abgistrar's Signature	11-1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	31000
	Registra	ar a	FEB 2 8 2007 Brown & South D			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Fogle Mary Frances АМ February 23 2007 5:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 213-28-6479 Director 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show Show 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō other traumatic sysnt, the Madical Examiner must be 7900 Benesch Circle Apt. 783 238 21060 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? or Items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: Specify. White 3 ☐ Widowed 4 ☑ Divorced 'nsturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) Coflege (1-4or 5+) 11 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If itsm 27 is marked o Grover Fred Shiflett Ruby Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Stewart 8493 Williams Mill Pond Road, Delmar, MD 21875 (daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 26 20c. Location - City or Town, State Department of H important: If its sny Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2007 permit. 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between fmmediate Cause (Final disease or condition Onset and Death metastation Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), ast Due to (or as a consequence of): Examiner death certificate be executed ete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year P.O. I 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 **XD**Vo of Vital 1 Yes 1 ☐ Yes 2 ☐ No Physicisn: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient 1 Yes 2 No Other: ٩ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Hospital To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D 8 ddress of person who completed cause of death (ftem 23a) (Type, Print) 2/061 OAKWOOD ROAD GlenPurnie MA 7845 Jude Munesea 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 28

			For State Registrar	State of Ma	aryland /	Depa	artmer	nt of H		and M	•		ne o	107	06	01!
	Physici /Medic		1. Decedent's Name (First, Middle, La	,	S						2. Date of D Month FEB	Death	ay 200	Year 7	3. Time (	of Death
j	Examin		4a. Facility Name (If not institution, give	re street and number)			,		Location of			4		y of Death		
			Genesis Brightwo						ville					11timo		
	Funeral		5. Social Security Number 6. S	Sex 7.Ag IX∏M 2□F	e (In yrs. last 81	birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of E (Month, I June	Birth Da <i>y, Y</i> ea <b>/. 1</b>	<sup>r)</sup> 925	9. Birthp Cour Mary	olace (State ntry) 1 and	or Foreign
	Director		219-18-0178 Usual Residence of Decedent		01					1	Julie	-+ , <u> </u>	723	Hary	Land	
	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10a. State 10b. County  MD Baltimo	re	10c. City, To		ville									City Limits
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n	after deat or items 2 niner mu	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 XYes 2 1 Yes, Give							ecify Yes or N Rican, etc.)	No-	Bla	ce - Americack, White,	etc.	
2	ural", c	by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	'43-45		i∟ires dent's Usu		Specify:			4.05		ify: <b>whi</b> Business/In		
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<u> </u>		ပို	Benjamin Flaks  19a. Informant's Name/Relationship	Time Orint)		Ob. Mailie	an Addron	2 /Ctroot			layman Il Route Nun		T	01-1- 7:-		
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	Physician /Medical		Immediate Ca se (Final disease or condition resulting in deat	a. Con	GEST	1101	= 1	HEF	RT	FI	41601	Q E			Nove	
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Cords, P	requires that the death een signed by the atter nould be detached for u	by	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying	cause give	en in Part I	ļ.				ntribute to th	he cause of	death?
ב	iclan: The law requires tha certificate has been signed I rector, page 2 should be det	Completed			· · · · · · · · · · · · · · · · · · ·						24a. Wa aut per 1∐ Yes	topsy rform <u>ed</u> ?		prior to con death?	psy findings mpletion of 2 \square	s available cause of
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	the Hospital or Attending Physician: in 24 hours after death the Funeral Director: After this certific npletely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	e 290 Plans of inju	ury - At home c. (Specify)	, farm, sti	eet, facto				28f. Location City or T	(Street a	Street and Number or Rural Route Number, wn, State)			mber,
	Hospit 24 hours Funers	ledical C	29a. Certifier (Check only one)  Certifying Plants 2 Medical Example 2	hysician: To the best miner: On the basis o and manner sta	f examination	dge, deat and/or in	h occurred vestigation	d at the tin	ne, date ar pinion, dea	nd place, a ath occurr	and due to the	e, date a	(s) and m	nanner as s , and due to	tated. o the cause	(s)
	o the Hos vithin 24 ho o the Fur completely	Mec	29b. Signature and title of certifier	and montal ste			29	c. License	number			29d. E	ate sign	ed (Month,	Day, Year)	

Vit Vit

29c. License number 29d. Date signed (Month, Day, Year)

Ship HMD DOOS 315D FEB 20 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn HALA GUTH 9650 Southof Road, Secte 110 40 2045

31. Date filed (Month, Day, Year)

FEB 2 8 2007 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death February 22, 2007 **Physician** 10:15 PM M Claire Fayolle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 03/29/1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign Months Days Hours 1 M 2 F Canada, 101-36-9096 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 7 is marked other then "neturel", or items 23a or 28e-f show treumatic event, it a Madical Examination state retifical at 1 ☐ Yes 2 No MD Baltimore Towson Director illed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 E Joppa Rd. 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White þ 3₺ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Beaux-Arts . Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f Iment of Health and Mental F tent: If item 27 is marked of Joseph Dufresne Jeanne Perault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. Fayolle/Son 105 W. 55th St. New York, NY 10019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb 26 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If it any injury or conce. Beltsville, Maryland 2007 Chesapeake Crematory '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Physician minutos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) attending physicien Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ţ Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Vuscular Hecident 2 210 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s autopsy certificate 1 TYes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours a 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0061199 Feb, 23 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 North Charles ST, Suite 209, Touson MD 21204 Black MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

FEB 28

2007

Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** GUNTHROP 10:01 Am 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE DUPONT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. Maryland Director 11/05/1945 218-42-5949 61 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1XYes 2 No Directo Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2913 Dupont Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after ☐Yes 2☐XNo fYes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: "natural" Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene. ant: If Item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Nina Strickland Lee Gunthrop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Marie Franks / Sister 2913 Dupont Avenue, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/05/2007 Baltimore, Maryland King Mem. Park 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts., Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HYPERIGNSION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed HIV + burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P nours after death. neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number

To the Hospital or Attending within 24 hours a

To the Funeral I

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10059876

29d. Date signed (Month, Day, Year)

4120 PATTERSON NE. BALTO, MJ 2/40

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

onna S Goins		Sta 1- For State	ate of Maryland	/ Depa		Health a			giene	20	0601	
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle Donna S. Coi			-			T	2 Date of Deat Month February 1		3. Time of Death 0216 hrs	
	ı	4a. Facility Name (if not institution Malcolm Grow				4b. City, Town Camp Sr		on of Death		4c. County of Prince G		
Funeral Director		5. Social Security Number 578–15–5656		e (In yrs. Ia	ast birthday) Yrs		Year If U Days Ho	urs Min.	8. Date of Birt		9. Birthplace (State or Foreign Wash., D.C. Country)	
n with the Maryland ms 23a or 28a-f show any be notified at once.	Director	10e. Street and Number 714 71st Ave	12. Was Decedent	Ever in U.	S. 13. Wa	apitol	de 2	0743 Origin? ( Spe	ecify Yes or No-	Dg. Citizen of Wh U.S.A.	- American Indian, Black,	
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e, MD 2121 I and 2 should be fi Health and Mental I item 27 is marked r traumatic event,	_[	19a. Informant's Name/Relations Leshon I. Goin		l non-	714 7	1st Av	e.,Ca	pitol	Height:	s,Md. 2	n, State, Zip Code) 20743	
Baltimore, permit. Pages l ar Department of Hee Important: If ite injury or other ir		Burial 2 X Cremation 3 Removal from State crematory or other place)  Chesapeake Crematory, Inc. 2/27/07 Beltsville										
		21. Signature of Funeral Service Licensee  22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.										
Physician /Medical Examiner		failure. List only one cause  Immediate Cause (Final disease or condition resulting in death)	on each line.	rythmia	a	ie mode or dy	ing, suoir a	o cardiac or	respiratory arre	sat, shook, or nee	Approximate Interval Between Onset and Death	
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b									
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ox 68760 ath certificate by attending physion ruse as the bu	sician/	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Unit	4 Pregnant at	me of pregi	nancy 2 Fe	3/23/07  tal death  her (Specify)		opic pregnar	ncy	23d. Date of Month	delivery Day Year	
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of Vital Recong Physician: The law After this certificate has uneral director, page 2 s	To Be	25. Was case referred to medica examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1 Inpatio	لـــــا	ER/Outpatient	3 DOA	Other		g Home 5	Residence 6	Other:	
Division of Vital Ital or Attending Physician. rs after death all Director: After this certiled in by the funeral director.	ertification:	1 X Natural 5 Pend Investigation	stigation 28e Place of I	Year)		1[	Yes 2	. No			er or Rural Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	0	4 Homicide  29a. Certifier 1 Continue B	Id not be (Specify)  hysician: To the best of m						or Town, S		as stated.	
To the Hos within 24 h To the Fut	Medical	(Check only one) 2 ✓ Medical Example 29b. Signature and title of certific	miner:On the basis of exa and manner stated	amination a	and/or investiga	tion, in my opi	inion, death	occurred a	t the time, date	and place, and d	ue to the cause(s) ed (Month, Day, Year)	
		Je luna Bla  30. Name and address of person	AND (M) MY	death (Item	23a)	0	.C.M.E.			February 1	8, 2007	
<i>X</i>		Melissa Brassell, MD	Assistant Medica		ner 111 F	Penn Stree	t, Baltim	ore, MD	21201			
St Regist	ate rar	FEB 2 8	3 2007 1	er a	R A	5.60						

ORIGINAL

State Registrar 30. Name and addre

77 VAT VHE TEXAN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

npleted cause of death (Item 23a) (Type, Print)

RIYER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) FEBICIARY 27 2007 **Physician** 1.10. A M Meakie Μ. Hampton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Baltimore washington medical Center Arundel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F 219-32-3441 Yrs. Sept. 91 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be collified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Highland Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specity: Specify: þ White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelith and Mental Hy Important: if Item 27 Is marked oth any injury or other traumatic event sons: Be Unknown Potter 2 Bonnie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curt C. Bradshaw II 4 Highland Road, Glen Burnie, MD 21060 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery March 2,2007 Baltimore Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 4 □ Donation 5 □ Other (Specify) 21. Signature / Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one column on each Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) AINOMUSHA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Examir Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2₩No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28d. Describe how injury occurred Certification: After 1 atural 5 Pending I Director: A death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours after To the Funeral Direct

State Registrar

301 roportal le 31. Date filed (Month, Day, Year) FEB 2 8 2007 2. Registrar's Signature

ss of person who complete

29b. Signature and its of certifie

cause of death (Item 23a) (Type, Print)

29c. License number 45149

07-01247 Travis Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 0602 |

		- For State Registrar		Certifi	cate of L	Death			Reg. No.				
Physiciar		Decedent's Name (First, Middle, L.	ast)					2. Date of D	eath			3. Time of Death	
/ledical Examin		Travis Harris						Februa	y 14, 20	Year 007		1635 hrs	
A Company		4a. Facility Name (if not institution, g	ive street and number)			City, Town, o	Location of [	Death	4c	. County o	f Death		
Francis	4	5. Social Security Number 1 n k 6.	Sex 7 Age	(In yrs. last b		If Under 1 Yea	ar If Under 2	AHrs. 8 Date of	Birth/MM/	DD/YYYY	9 Birth	place (State or	1 .
Funeral Director		,	X M 2 F	66	_	Months Day		N.A.	8, 1		Foreign Cour		ınk
	-	Usual Residence of Decedent										104 14- 0:1	1
w any		10a State 10b. County		Tuc. City, Tow	n or Location							10d Inside City I	
Maryland 28a-f show d at once.	٥	MD			Balti							71	_ NO
Mary 28a- d at c	Director	10e. Street and Number			1	Of. Zip Code			10g. Citi:	zen of Wha	at Count	ry?	
ith the Maryland 23a or 28a-f sho notified at once		3116 Wilkens Av				2122	29			US	A		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	unera	11. Marital Status un Never Married 2 Marrie	12. Was Decedent I	ver in U.S. un				? (Specify Yes or uerto Rican, etc.)	No-	14. Race - White,		an Indian, Black,	
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s afte	⋧┞		ed If Yes, Give Year or Dates:	Notod) [166		es 2 X No		d of work dong n		Specify: Kind of Bus	whi	d et e .	
5-0036 ted within 72 hours after type within 72 hours after type wither than "natural", the Medical Examiner	Completed	15 Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5		during most	of working life	e. DO NOT us	e retired)	k liob.	VIII OI DUS	1110337111	t	ınk
36 nin 72 than dical	ᇍ	unk	unk	′									
d with	ᇊ	17. Father's Name (First, Middle, La				unk	18.Mother's	Name (First, Midd	le, Maiden	Surname)			ınk
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	8					ank						·	IIIK
7 Pa & E 3 .		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing A	ddress (Stre	et and Numbe	er or Rural Route I	Number, Ci	ity or Town	, State, 2	Zip Code)	
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Baltimore, permit Pages I a Department of He Important: If ite	H	21. Sixcelure of Funeral Service Lic	ensee	S		ne and Addres							
Balt permit Departi Import injury		Romald S	Wade, Dire	etor	Stat	e Anat	omy Bo	ard 655	W. Ba	1timo	ore :	Street	
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- /Medical			a Head and Neck	Injuries								Death	
Examiner		or condition resulting in death)	Due to (or as a conse	quence of):									
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760, ficate b	ĕ¦	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom						230	d. Date of o	•	V	
68° certifi	ä	past 12 months?	1 Live birth 4 Pregnant at t	ime of death			Ectopic p	regnancy		Month	Da	iy Yeai	
Box 68: death certif	Š	1 Yes 2 No 9 Unkno			J Otne	(Specify)			1				
, P.O. Box 68 res that the death certificing signed by the attending be detached for use as		Part II. Other significant condition	s contributing to death	but not result	ting in the und	lerlying cause	given in Part	I. 23e. D	d tobacco	use contrib	oute to th	e cause of death	1?
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Vital   ysician: his certifi director,	മ്	examiner?	Hospital: 1 Inpatie	nt 2 FR	/Outpatient :			Nursing Home 5	Reside	nce 6 🗸	Other:	Scene	
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isic Atte rector	<u>[g</u>	2 Accident Investig	28e Place of Ini		320 hrs , farm, street,	factory, office	building, etc.	28f. Location	n (Street a	nd Numbe	r or Rura	al Route Number	City
Division of Vital Records, ospital or Attending Physician: The law require hours after death the Physician: The law requiremental Director: After this certificate has been siy filled in by the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director.	Certification:	Suicide 6 Could n  determi		gle Family				or Tow 3116 Wilke	n, State) ens Ave, I	Baltimore	, MD		
9 - 3 - 5	- 1	29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge,	death occurre	d at the time,	date and place	e, and due to the o	ause(s) an	nd manner	as stated	d.	
To the within 2 To the Complet	Medical	one) 2 Medical Examin	ner: On the basis of exar and manner stated.	nination and/o	or investigation	n, in my opinio	n, death occu	rred at the time, d	ate and pla	ace, and du	ue to the	cause(s)	
F. 2 E. 8	₽	29b Signature and title of certifier	In N			29c. Licen	se number		29d.	Date signe	d (Mont	h, Day, Year)	
		Melin Bras	sell all			O.C	.M.E.		Feb	ruary 15	5, 2007	7	
	ŀ	30. Name and address of person wh	no completed cause of d	eath (Item 23a									
			Assistant Medical				Baltimore,	MD 21201					
Sta	ite	31. Date filed (Month, Day Year)	32 Registrar	's Signature	Speed	وع							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year WILLIAM HARRIS, FEBRUARY 24 2007

1. Decedent's Name (First, Middle, Last) **Physician GEORGE** 11:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Apr 26, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days M 2□ F 215-42-3719 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 612 W. Patrick Street #3 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 9 3 Widowed 4 Divorced 'natural', the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. 10 Business Owner Architectural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Harris Katherine E. Rothenhoefer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sheila D. Harris/wife</u> 612 W. Patrick St. #3 Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 02/28/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. BOX 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hsystole 2 days Physician disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner bul monony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 🗆 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after deam.

To the Funeral Director: After th 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATIMA PANDEY 400 W. 7th Street Frederick, MD 21701 31. Date filed (Month, Day, Year)

State Registrar

FEB 2 8 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) CHARLES HAEGERICH 8:07 AM **Physician** PEBRUARY 23 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HARBOR HOSPITAL 3ALTIMORE N/A 8. Date of Birth (Month, Dey, Year) Sept. 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 4 1 M 2 □ F **Funeral** Months Days Hours 12 18 86 Yrs 1920 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Anne ARundel Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 420 Church Street 21225 U.S.A. or items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other then "natural," or Herr any injury or other traumatic svent, the Mattern any injury or other traumatic svent, the Mattern and ODCS. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 2 years School System Purchaser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles W. Haegerich Sr. Ida M. Rollman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary W. Haegerich / son 340 Logan Drive Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 2/27/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ettine of Funecal Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23d. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. HEART FAILURE Immediate Cause (Final CONGESTIVE **Physician** disease or condition resulting in death) /Medical Examiner EREBROVASC ULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner YPERTENSION attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ATION MYOCARDIAL INFARCTION Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 ÜUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1BRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an irector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 (9Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this Director: After that in by the funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien:

altimore, Maryland 21215-0036

within 24 hours a To the Funerel I

State Registrar

RES

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 3001 SOUTH HANOVER STREET, BALTIMORE, MD, 21225 MENGESHA

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 2 8 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John Paul Hanna FEBRUARY 26, 2007 06:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | March | 6 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Renick, W 234 20 7220 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Joppa 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 829 Old Joppa Road 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 □ Divorced WW TT White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) other than Letter Carrier US Postal Service rmit. Pages 1 and 2 should be filed w ppartment of Health and Mental Hygien portant: If item 27 is marked other the ly Injury or other traumatic event, the oriould be file. Alth and Mental Hvo 7 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Harry Hanna Vera Givens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Meadow Road Bel Air, Maryland 21014 P. Gary Hanna Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or St Paul's Luth. Ch Cem. March 2 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Si va ure of Funeral Service Licensee 22. Name and Address of Facility 11750 Belair Road EF Lassahn Funeral Home PA Kingsville, Maryland 21087 23a. Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC DYSRHYTHMIA /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician s the burial Physician/Medical as attending p IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 □ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s certificate has autopsy 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? No Hospital: Other: 1 TYes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 \Bursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Certification: 1 Natural 2 Accident (Month, Day Year, Injury 5 Pending 1 ∏ Yes 2 ∏ No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and title of de 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) D24034

DHMH 17 Rev 1/2001

State Registrar TOWSON, MARYLAND 21204

OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

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2007

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FEB 28

YHTOMIT

31. Date filed (Month, Day, Year)

		` .	Please Type or Print in Bla  State of Maryland	/ Depa	rtment of H	Health and N	-	FR 15 1	06025
			Registrar	Cer	tificate of	Death	1	Reg. No.	
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Philip Howell Hall				2. Date of De Month Februa	Day	3. Time of Death 2007 9:37 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County	ol Death
			Atlantic General Hospital			erlin			rcester
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F 68	t birthday) Yrs.	Months Days		8. Date of Bi (Month, D. Sept.	ay, Year)	9. Birthplace (State or Foreign Country) Maryland
	D >-22		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Town or Loc	ration				10d. Inside City Limits
	after death with the Maryland or Items 23s or 28s-f show miner much be notified at	<u></u>		OWIT OF LOC		o			1 ☐ Yes 2X No
	Ba-f	ecto	Maryland Worcester		Ocean (	City		10g. Citizen of V	What Country?
	with the	Funeral Directo	10e. Street and Number		10f. Zip Code	<i>(</i> )		-	
	er death wi	ral	13328 Constitutional Avenue  11 Marital Status  12. Was Decedent Ever in U.S.	12 V	2184		acity Vas or N		S. A. e - American Indian,
	item item	Ë	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No	lf.	Yes, specify Cub	Hispanic Origin? (Sp Jan, Mexican, Puerto	Rican, etc.)	Blac	k, White, etc.
) 0036		by F	If Yes, Give  3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 21 No	Specify:		Specify	White
79	within 72 hours ene. then "naturel", he Medical Exe	bed		16a. Deced	ent's Usual Occur	pation		16b. Kind of Bu	usiness/Industry
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2 Q Z	filed with Hygiene other the	Completed	2 years	Bu	ilding Ma	anager			iversity
ر الرو 1/خ Jand	S should be filed within and Mental Hygiene.  is marked other than aumatic event, the Mental County and County the Mental County the Menta	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	·		ne)
<u>_</u> <u>a</u> <u>b</u> <u>C</u> O	uld b Ments prked affice	2	Gordon H. Hall			E1.	sie Hun	tt	
2 0 P	and I				•	and Number or Rui			
O O ≥	s 1 and 2 should be filed within 7 if Health and Mental Hygiene. Item 27 is marked other then "n other traumatic event, the Med		Betty Hall (Wife)						y, Md. 21842
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O DE	Pag ment ant: ury c		4 Donation 5 Other (Specify)		alley Mer				m, Maryland
	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee						Home of Bel Air, Md. 21014
	20.5 # d		Differre Knoke						
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one causa on each line.	Do not ente	er the mode of dyi	ing, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	1	nyen	Discus	79		(eesg
	/Medical Examiner		resulting in death)  Due to (or as a consequent	nce of):	/				
	Examiner	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequent	non of):					
4	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	108 01).					
8	be executed sicien and burial-transit	xan	that initiated events c.  resulting in death) Last Due to (or as a consequence)	nce of):					
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387	phys phys s the	de	d						
Box 687	death certificate e attending phys d for use as the	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance 10 line birth 2 Destruction					23d. Da	te of delivery
B	eath atter	clar	in the past 12 months?  1 □ Yes 2 □ No		Ectopic pregnanc Other <i>(specify)</i> _	:у		Mo	nth Day Year
Ó		lsk	9 Unknown 9 Unknown						
36	requires thet the death certificate neen signed by the attending phys hould be detached for use as the	by Physician/Medic	Part II. Other significant conditions contributing to death but not resulti	ing in the ur	nderlying cause gr	ven in Part I.	23e. Did	tobacco use cont	ribute to the cause of death?
₩ sp	quire in sig uld b						10	Yes 2□No	3 Probably 4 Unknown
9	≥ .0 ′0	Completed					24a. Wa	s an 24b.	Were autopsy findings available
- e	The lav	통					auto perf	ormed?	prior to completion of cause of death?
City In	sician: Th certificate rector, pag	BeC	25. Was case reterred to medical	-		26. Place of Dea			10163 2000
Ξ, Ξ	Physician: this certific ral director.	To B	examiner?  1 Yes 2 Ne Hospital: 1 Inpatient 2 EF	R/Outpatien	t 3 DOA Ot	her: 4 Nursing H	ome 5□Res	idence 6 Oth	er (Specify)
500	ding Phys n. After this funeral di		27. Magner of Death 28a. Date of Injury 2	8b. Time of Injury	28c. Inju Wo	iry at	28d. Describe	how injury occur	red
_Q.0	inding ath. ir: After ie funei	atlo	2 Accident investigation	in july		Yes 2 No			
Z * S	r Atte	1	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, larm, str	eet, lactory, office			(Street and Numb own, State)	er or Rural Route Number,
\$ 000	itei or rs afte al Dir led in	Certification:	33.33.10,003.37					,	
T()	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2		29a. Certifier  (Check only  2 Medical Examiner: On the basis of examinatio	edge, death	occurred at the treatment occurred at the treatment of th	time, date and place opinion, death occu	, and due to the	cause(s) and ma	anner as stated. and due to the cause(s)
	the H hin 24 the F nplete	Medical	one) and manner stated.						d (Month, Day, Year)
	o T Me T o O	2	29b. Signalous and title of certifier		Licen	se number	9	23u. Date signe	) ) / Par
	1		100 min	J	00	010	/	0/0	1010
	11		30. Name and address of person who completed cause of death (Item 2	:3a) (Type,	Print)	1 . 11	C		<u> </u>

State Registrar

We Chales Derolulin, up 1209 Constal Highway

31. Date liled (Month, Day, Year)

FEB 2 8 2007

Some Strange Signature

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07-0	1000

7-01536 athan David H					ene	2007	0602
Physici ledical Exami	an/	Registrar  1. Decedent's Name (First, Middle,Last)  Nathan David Holmack	meate of Death		Reg No North Dar ebruary 24,	v Year	3. Time of Death 1330 hrs
		Facility Name (if not institution, give street and number)     4401 Bronze Wing Court	4b. City, Town, o Nottinghan			4c. County of Death Baltimore Cour	•
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. las	st birthday)  If Under 1 Ye  Months  Day	ar If Under 24Hrs. 8. ys Hours Min.	Date of Birth(M	M/DD/YYYY) 9. Birth Foreign Cou	nplace (State or South ntry) Carolina
aryland 8a-f show any at once.	j.	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  Maryland Baltimore	own or Location  Nottingha	um			10d. Inside City Limits  1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 4401 Bronze Wing Court	10f. Zip Code	21236	10g. (	Citizen of What Coun	try?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Mental Hygien 27 is marked other than "natural", or items 23a or 28a-f She matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced  12. Was Decedent Ever in U.S  Armed Forces?  1 Yes 2 X No  11 Yes 2 X No  11 Yes 2 To Dates:		an, Mexican, Puerto Rica	an, etc.)	14. Race - Americ White, etc.	te
5-0036 led within 72 hours. Hygiene. other than "natur:	ompleted t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occupion during most of working lif			o. Kind of Business/Ir Restaw	
21215-0036 uld be filed within ? Mental Hygiene. marked other than e event, the Medica	Be Cor	17. Father's Name (First, Middle, Last)  David G. Holmack		18.Mother's Name (Fin Sandra	Hard	y	
e, MD 21 1 and 2 should Health and Me item 27 is ma r traumatic ev	To	19a Informant's Name/Relationship (Type, Print)  David G. Holmack (father)	19b. Mailing Address (Street 4401 Bronze lace of Disposition (Name of control of the street street and the street	e Wing Cour	t, Nott	City or Town, State, ingham, MI	21236
of F		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	rematory or other place) LGORD Mem'L Ga	rdens 3/1/2	2007 B	el Air, M	aryland
		21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the death.	9705 Belo	ss of Facility Schin	ltimore,	, MD 212	
Physician /Medical Examiner	0.0	23a. Part I. Enter the disease, or complications mat caused the death.  failure. List only one cause on each line.  Immediate Cause (Final disease a. xycodone intoxi or condition resulting in death)  Due to (or as a consequence of)	cation	g, Suci pas cal diac or re-	spiratory arrest,	SHOOK, OF FIGURE	Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of)					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death from the certificate has been signed by the attending physician in the Finneral Director. After this certificate has been signed by the attending physician is completely filled in by the firmeral director, page 2 should be detached for use as the burial -	Physician/Medi	## Zid, Zi, Zod=1, p  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  ## Zid, Zi, Zod=1, p  23c. If yes, outcome of pregn  1 Live birth  4 Pregnant at time of deal  9 Unknown	ancy Petal death 3	3 Ectopic pregnancy	- 1	23d. Date of delivery Month D	ay Year
P.O. B s that the de gned by the	þ þ	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause	e given in Part I.		cco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  The Invector, After this certificate has been signed by all not inverted director, page 2 should be deadd.	Completed				24a. Was an autopsy performer 1 Yes 2	prior to death?	topsy findings available ompletion of cause of
Vital Rechysician: The this certificate this director, page	To Be (	25. Was case reterred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursing H	lome 5 Res	sidence 6 🗸 Other	Scene
Division of Vital Rec Within 24 hours after death To the Funeral Divisoror: After this certificate I	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year) FNd 2/24/2007	Fnd 1:25 pm	Yes 2 X No	unk		ral Route Number, City
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the	Certification:	3 Suicide 6 X Could not be determined (Specify) House	ome, farm, street, factory, office	N	or Town, State otingham,	*) 4401 Bron MD	ze Wing Court
To the Hos within 24 h To the Fur	Medical		nd/or investigation, in my opini	ion, death occurred at th	ne time, date and	d place, and due to th	e cause(s)
	¥	Janut Buthey min	0.0	c.M.E.		9d. Date signed (Mo.	
		30. Name and address of person who completed cause of death (Item Pamela E. Southall, MD Assistant Medical Exal 31. Date filed (Month, Day, Year)	miner 111 Penn Stre	eet, Baltimore, MD	21201		
	State strai	The second of th	A. A.				

Registrar

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Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)						2. Date of Deat	h		3. Time of Death
edical Exami		ANTONIO LAMONT	HARRIS					Month February 2	Day 23, 2007	Year	2130 hrs
		4a. Facility Name (if not institution, give	street and number)		41	b. City, Town, or L	ocation of Dea	th	4c. Co	ounty of Death	
		University Hospital				Baltimore	Ligitation	- Io pata aspir	h (144)DD	N/A	h-1 (Ot-1
Funeral Director		5. Social Security Number 6. Sex		e (In yrs. last b		If Under 1 Year Months Days	If Under 24H		,	Foreig	hplace (State or
Director			M 2 F	18	Yrs.			4-28	-1988	S Cot	untry) MARYLAND
iny		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Locatio	n					10d. Inside City Limits
id how s		MD. N/A		BAI	TIMOR	E					1 XYes 2 No
arylar 8a-f s at on	읈	10e. Street and Number			-	10f. Zip Code		10	g. Citizen	of What Cour	itry?
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	1013 BENTALOU ST.				2121	6		119	SA	
with ms 23. be no	eral	11. Marital Status	12. Was Decedent Armed Forces?				panic Origin? (	Specify Yes or No-			can Indian, Black,
death or ite	اجَ	1 X Never Married 2 Married	1 Yes 2	X No				to Ricari, etc.)		vvinte, oto.	
after ral",			If Yes, Give Year or Dates:	1-1B 140		Yes 2 No		Fundi dana		ecify: BLA	
hours 'natu Exar	Ę.	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5			s Usual Occupation st of working life. I			IOD. KING	of Business/l	ldustry
36 nin 72 e. than 'dical	ble			,	NT	/ A				N/A	
d with	Completed by	-8- 17. Father's Name (First, Middle, Last)	-0-		N	/ A1	8.Mother's Nan	ne (First, Middle, M	laiden Sur		
21215-0036 Motal Filed within 72 hours after death with the Maryland Motal Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Be	JEROME HARRIS			_		CYNT	HIA GRIS	SOM		
21 nould id Mei is man	မှ	19a. Informant's Name/Relationship (Ty	pe, Print )		19b. Mailing	Address (Street	and Number or	Rural Route Num	ber, City o	or Town, State	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If rigen 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		BERNICE KICE (GRAN 20a. Method of Disposition	DMOTHER)	20h Bloc		BENTALO		ALTIMORE Date		RYLAND ation - City or	
of Hear In the hear tr		1 XBurial 2 Cremation 3	Removal from Sta		natory or oth		letery,	Date	200. 200	allon Olly or	Town, Otato
LimC Pag Iment Tant:		4 Donation 5 Other Specify:		MT.	ZION	CEMETERY	3-	1-2007	BALT	CIMORE.	MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medical		21. Sign 1 19 f Funeral Service I cen	LAH YAM L	D. HI							
Physician		23a. Part / Enter the disease, or compli	cations that caused	the death. Do	not enter th	e mode of dying, s	MONROE such as cardiac	or respiratory arre	St, shock,	orheart	Approximate Interval
/Medical	9	failure. List only one cause on eac									Between Onset and Death
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Box 68760, death certificate be he attending physicid for use as the burn	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregnar		al death 3	Ectopic preg	nancy		ate of delivery onth E	/ Day Year
cath certific eath certific attending for use as t	icia	past 12 months?	4 Pregnant at	time of death	- =	er (Specify)					
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rds, Frequires	ted							24a. Was	an	24b. Were au	topsy findings available
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t of Vit ling Physic After this funeral dir	<u>د</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Init	urv 28	3b. Time of Ir		y at Work?	28d. Describe	now injury	-	
Division of Vital Records, tal or Attending Physician: The law require as after dealh all birctor: After this certificate has been sited in by the funeral director, page 2 should be	tion	1 Natural 5 Pending	Feb 23, 2007	<sup>(ear)</sup> 2	050 hrs	1 Y	es 2 🗸 No	Subject sho	t		
riSiC r Atte er dez irecto n by tl	fical	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Ir	njury - At home	e, farm, stree	et, factory, office bi	uilding, etc.	28f. Location (S		Number or Ru	ıral Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined		dewalk				1600 block M	cKean Av	venue, Baltir	nore , MD
Hosp 24 ho Fune etely f	alC	29a. Certifier (Check only 1 Certifying Physicia	an: To the best of m	ny knowledge,	death occur	red at the time, da	ite and place, a	nd due to the caus	e(s) and n	nanner as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	edical	one) 2 Medical Examiner:	On the basis of exa and manner stated.		or investigat			u at the time, date			
	ž	29b. Signature and title of certifier	, , ,			29c. License O.C.M				te signed ( <i>M</i> o. ary 24, 200	nth, Day, Year)
			ey Mr			0.0.1	VI.L.		Lebiu		
1)		30. Name and address of person who can Tasha Greenberg MD.	completed cause of a Assistant Medic			Penn Street, I	Baltimore. N	MD 21201			
	tate		AB	ar's Signature	2.5	3366	31.				
	تدانته	- 10 C	"71111/ TISS	CONT OF MANAGEMENT A	9 A						

			-	For State Registrar	State o	f Marylan	,	irtment of tificate o			_	giene Reg. No	Z 11 11 1	06028	
		Physicia		Decedent's Name (First, Middle, La     Goldie Coretta	-						2. Date of De Month	Da	Year Year	3. Time of Death  7 43 M	
		/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town	n, or Location	of Death	Arra		: County of Deal	h an	
		- uneral	N	Levindale  5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Ye		r 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign	_
	D	Director		217-14-1052	□M 2 <b>X</b> )F		88 Yrs.	Months Da	ys Hours	Will.	08/03/19	918	,	MD MD	_
	Maryland	f show	jo.	10a. State 10b. County MD		10c. Cit	y, Town or Lo	Baltim	ore					10d. Inside City Limits 1 X Yes 2 □ No	
	with the	s or 28s-1 sho	Direct	10e. Street and Number 3526 Langrehr Road A	ot. 1-D			10f. Zip Cod	e 21244			10g. Ci	itizen of What Co	ountry?	
	laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	r Iteme 23	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Dece Armed Fo	2 X No		Vas Decedent	of Hispanic O Juban, Mexica		cify Yes or No Rican, etc.)	D-	14. Race - Ame Black, Whit	e, etc.	
	Maryland 21215-0036	natural', o Ilcal Exar	ted by	3 Widowed 4 Divorced  15. Decedent's E. (Specify only highest gra	If Yes, Gin Year or D	/e ates:	16a, Deced	Yes 2X1	cupation		na	16b. k	Specify: Afr Ame (ind of Business)		_
	2121	the Me	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. L	oo NOT use re cleri	tired)		.9	Soc	ial Secur	ity Administrat	ti
	fand d be file	ked other	To Be	17. Father's Name (First, Middle, Last Arthur					18. Moti	her's Name	(First, Middle Emma S				
	≥ 0:	드는 그		19a. Informant's Name/Relationship (Pamela C. White / Daug	,, . ,								or Town, State, 2 , Maryland		N
. 7	Baltimore,	Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 \( \overline{\text{Z}}\)Burial 2 \( \overline{\text{Cremation}}\) Cremation 3 \( \overline{\text{U}}\)		State	emetery, cren	sition (Name of natory or other lark Ceme	place)	03/02/	ate 2007		ocation - City or		
go/ch	Balti permit.	Departm Importsi any inju		21. Signature of Funeral Service Lice			22	. Name and Ad		Wyı			ome, P.A.	land 21217	
5				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o one cause on e	caused the deat	h. Do not ent	er the mode of	dying, such a	is cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	//\	ysician Jedical		Immediate Cause (Final disease or condition resulting in death)	a	(or as a conseq	yuence of):	a a	ull	y N	nie- Difee			76 mails	
}		aminer	ler	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	b	(or as a conseq	uence of):	ry	arc	ery	vifee	ne	-	76 moulh	_
erso	),	n end al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to	(or as a conseq	uence of):								
End	68760	physicie s the bur	dical	(	d										
工	P.O. Box 6	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpetfs? 1 □ Yes 2 ☑ No 9 □ Unknown	1□Live b	tcome of pregna pirth 2 Peta nant at time of d own	death 3	Ectopic pregna Other (specify					23d. Date of de Month	ivery Day Year	
	ds, P.	signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to						tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Monknown					
	Division of Vital Records, for Attending Physician: The law requires I	ate has beer page 2 shou	Completed								24a. Was auto perfe		death?	utopsy findings available completion of cause of	
	Vita sician:	r this certificate has	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA	Other		n (Check only		6 □Other (Spe	cify)	
	on of	After this funeral o		27. Manner of Death 1 ☑Naturat 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. I	njury at Work?		28d. Describe			ony	
	Division or Attende	after deatl Director: in by the	Certification	2 Accident 3 Suicide 4 Homicide		of Injury - At hing, etc. (Specif	ome, farm, str fy)				28f. Location ( City or To			ural Route Number,	
	Hospite	24 hours Funeral stely filled	edical Co	29a. Certifier 1 Certifying Proceedings one 2 Medical Exa	miner: On the b										
	To the	within To the comple	Me	29b. Signature and title of certifier	n p	W)_		29c. Lio	ense number	7		29d. Da	ate signed (Mont	h, Day, Year)	,
	4			30. Name and address of purson who	completed cause	se of death (Iter	n 23a) (Type,	Print) A	Ad	ned	ere	an	e Bel	1007 -	
		Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8 2	32. 5	gistrar's Signa	ature	naul!	.,,						
			W. C.	1 2 2 2 2	, C	CARLARY.	No. 18	ASTER STATE							

			- State Amend #5 Per	State of Ma FH G865 3	<b>761767</b> 59	partment of He e <i>rtificate of D</i>	ealth and N Death	lental Hy	giene Reg. No. ?	1 00000
			Registrar  1. Decedent's Name (First, Middle, La.	eath Day Year	3. Time of Death					
	Physicia /Medic		ETHEL REAN HAYN			T		my 26, 2007 10:05pm		
	Examin	er	4a. Facility Name (If not institution, giv	Location of Death MORE (	TITY	4c. County of Dea	ath			
4 V	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs, last birthda		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9. Bi	rthplace (State or Foreign
	Director		255 10 1005	□M 2XF	91 Yrs.	World 5 Days	TIOUIS WIII.			EST VIRGINIA
	land ow it		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f sh	tor	MD. N/A		BALTI	MORE				1 □XYes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	eath w	eral	3801 HILLSDALE  11. Marital Status	RD .	ver in U.S. 1	21207 3. Was Decedent of His		ecify Yes or No	USA 14. Race - Am	erican Indian,
(0	after d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X	)	3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)		
Ö	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						BLACK
21215-0036	in 72 h n "nati ledica	olete	15. Decedent's E (Specify only highest gro	ade completed)	(Gi	cedent's Usual Occupa ve kind of work done d n. DO NOT use retired)	uring most of work	king	16b. Kind of Busines	s/industry
212	d with giene. er thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) DC	MESTIC			PRIVATE	DUTY
	S la la	Be	17. Father's Name (First, Middle, Last WYATT ARMSTEAD	)				e (First, Middle C PERRY	, Maiden Surname)	
Maryland	should I	ဥ	19a. Informant's Name/Relationship	Type. Print)	19b. Ma	uiling Address (Street a			ner, City or Town, State,	Zip Code)
	and 2 sho ealth and n 27 Is m		ANNA JONES (SIST		3	801 HILLSD	ALE RD.	BALTIMO	RE, MARYLA	ND 21207
Baltimore,	pes 1 an of Heal of item 2 or other		20a. Method of Disposition	Removal from State	20b. Place of Dis	position (Name of rematory or other place		Date	20c. Location - City of	r Town, State
Ē	permit. Pages Department of I Important: If its any Injury or or		4 □ Donation 5 □ Other (Speci			OF ETERNAL			FINKSBURG,	
Ba	permit. Departr Imports any Inji		21. Signature of Eulogral Service Lice	MAHTANO)L **	HIBNE HIBNE				UNERAL HOM TIMORE, MA	E, P.A. RYLAND 21217
The second second	Physician /Medical Examiner		23a. Part1. cnt r the disease or conshock of eart failure. List only Immediate C use (Final disease or endition resulting in death)	_a	consequence of):	enter the mode of dying	g, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
	ps tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to (or as a	consequence of):					
P	execute and al-tran	Examiner	that initiated events resulting in death) Last	C Due to (or as a	consequence of):	<del></del>	<u>.</u>			
8760,	icate be executed physician and s the burial-transit	dical	•	d						
.O. Box 68	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ You' 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>			23d. Date of d Month	elivery Day Year
<u>α</u>	s that gned by	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	e underlying cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ord	w require been signature should b	ted k		<u></u>				10	Yes 2 No 3 I	Probably 4 Honknown
or Vital Records,	The la ate has page 2	Completed						24a. Was auto perfo		
VIII:	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	nt 2∏ER/Outpat	tient 3 DOA Othe	26. Place of Dea		one) idence 6 □Other (Sp	nacify)
1 Or	ding Phys n. After this funeral di		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury			how injury occurred	ВСПУ
Division	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	De Place of inju	ry - At home, farm, . <i>(Specify)</i>	M 1 □ \ street, factory, office	Yes 2□No	28f. Location ( City or To	(Street and Number or I wn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		hysician: To the best o miner: On the basis of and manner sta	examination and/o					
<b>\</b>	To the within To the COMP	Me	29b. Signature and title of certifier	2 mp		29c. License	number 64	7//	29d. Date signed (Mon	nth, Day, Year) 2 NJ
•	,7		30. Name and address of person who	Arl ST	. It fre	pe, Prihit) on fut c	of ha	1 hm	Wr. MJ	)
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2	32. Registra	r's Signature	Sales (				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** Ince 21:53PM 24 4KXIS 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner More If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 7. Age Birthplace (State or Foreign Country) **Funeral** Year) Days Months 1 □ M 2 🖫 F Director 219-45-3164 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified Director MD Baltimore Reisterstown the 10g. Citizen of What Country? 10e. Street and Number with 2303 Long Ridge U.S.A.

14. Race - American Indian, Road 21136 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Iem 27 is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes ♣☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th grade Student ns School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. Carlos Ince Tammy Hadley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 Long Ridge Road, Reisterstown, Md 21136 Carlos Ince-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 2/28/07 Pikesville, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrhy Thmia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Myocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for the a consequence of Examiner be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physiclan/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s autopsy 1□ Yes 2 No Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical (Check only one) 29b. Signatu 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) Volfe St Baltimore

State Registrar 31. Date filed (Month, Day,

FEB 2

DHMH 17 Rev 1/2001

ar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JOHNSON WAYNE 0626 19 FEBRUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F MARCH 11 1955 577 74 4584 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar process. unk | 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Arlington Director VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1554 Columbia Pike 22204 USA Funeral Was Decedent Ever in U.S. unk13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian, unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No black Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Medical Center Drive Rockville, MD 20850 Shady Grove Adventist Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\ Other (Specify) in state 21. Signatur Funeral Service Sicensee Wade State Anatomy Board 655 W. Baltimore Street Virgotor Baltimore, MD 21201 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final disease or condition resulting in death) SEPSUS Physician /Medical Due to (or as a consequence of): ENDUCARDITIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown cate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contified 00057129 2/12/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Truong Bao Shady Grove Hospital Rockville,MD . 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

FEB 2 8 2007

			For State Registrar	State of Maryla	•	artment of H			ene 0 0 7	06032
		á.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
+-1,	Physici	_	Marv Jane J	aecklein				2-2		7:20A M
	/Medic Examin	_	4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Deal	h
1		9	Manor Care Ruxton			Ruxt	on		Balt.	imore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. Bird	hplace (State or Foreign
	Director		219-28-7630	M 2QF	74 Yrs.	MOTHIS Days	Tiodis Will.	Sept. 2	9,1932 Ma	arýland
	P		Usual Residence of Decedent	100	Oits Town and					10d. Inside City Limits
	arylar show	_	10a. State 10b. County		City, Town or Lo					1 ☐ Yes 2 ☑ No
	Ba-f	cto	Virginia Fairfa	x co.	Anna	andale				^
	ith th	Dire	10e. Street and Number			10f. Zip Code	00003	10	og. Citizen of What Co	•
	23a	la	4212 Kings Mill				22003		United S	
	temes Turne	nue	11. Markar States	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerl	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
36	orl	Y	1 Never Married 2 Married 3 NWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	nite
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or Iteme 23a or 28a-f ehow thi, Ite Medical Examinat must be notified at	Completed by Funeral Director	15. Decedent's Educ		16a Dece	dent's Usual Occup	ation		16b. Kind of Business	/Industry
7	n 72 n na	jete	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of wor.			,
12	withi ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	r		Own Hor	ne
9	Hyg Hyg other	Ö	17. Father's Name (First, Middle, Last)			1.011101110110		ne (First, Middle, M		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 show or other traumatic event, It a Medical Examinat must be notified at	To Be	Lacey Charnock				Mary	Savolis	ski	
2	should nd Men marke umatic	-	19a. Informant's Name/Relationship (Typ	os, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
S	and 2 lealth a m 27 is her trau		Mrs. Felicia Schap	s / Daughter	4212	Kings Mi	11 Lane	Annanda1	e, VA 220	003
ē,	F Hea		20a. Method of Disposition	208	. Place of Disp	osition (Name of matory or other place			20c. Location - City or	Town, State
9	Pages nent of I ant: If Its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		istian Ce	· .	h 3, 2007	Fork, Ma	aryland
Baltimore,	글랜드 .	1	21. Signature of Funeral Service License			2. Name and Addre	1	11-11-1	5305 Harf	
Ba	Depa Impo eny i		) Macc	Michael Canal	γp	Leonard	J. Ruck	Inc.		
	A		23a. Part1. Enter the disease, or compli	cations that caused the de	eath. Do not en					Approximate Interval Between
	Dh i - i		shock, or heart failure. List only on Immediate Cause (Final		0	1000	. Δ		+	Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons		Vascu	clar /T	Calor		
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	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć	be executed sicien and burial-transit	Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be executed hysicien and the burial-transit	Cai								
9	tificate ig phys es the	Physician/Medical						<del></del>		
Вох	death certific e attending p od for use es t	S	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pre		⊒Ectopic pregnancy	,		23d. Date of de	
	0 0	Cia	in the past 12 months?  1 🗆 Yes 2 🐼 No	4 Pregnant at time of		Other (specify)			Month	Day Year
Ö.	at the de by the a steched i	hys	9 ☐ Unknown (	9LI UNKNOWN						
S,	The law requires that the tte bas been signed by the age 2 should be deteche	by P	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
ĕ	w require been sig should b							1 □ Ye	s 2 No 3 P	robably 4 Dunknown
S	aw re	ompleted						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
of Vital Record	The lav	E						perforn	ned? death?	
ta		C	25. Was case referred to medical				26. Place of Dea	th (Check only on		
$\geq$	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No	ospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth	19r: 4 🔀 Nursing H	lome 5 Reside	nce 6 Other (Spe	ecify)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time (	of 28c. Injur Wor	ry at	28d. Describe ho	w injury occurred	
Ö	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,	,,,		Yes 2 □ No			
Division		III C	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, s	treet, factory, office		28f. Location (Str. City or Town	reet and Number or A I, State)	ural Route Number,
Ö	pital or ours afte eral Dire	Certification:		1						
	Hospital     24 hours a     Funeral betely filled		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, dea	th occurred at the tir	me, date and place	, and due to the ca	ause(s) and manner a	s stated. e to the cause(s)
	To the Hos within 24 h To the Fun completely	edical	one)	and manner stated.	and and a					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1 /	7 . 1	29c. Licens	se number	25	9d. Date signed (Mon	in, Day, Year)
)			100	frace	20	O HO	05442	-4	2-16	-0/
	3		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type	, Print)		-	1110 7	1093
	2		Cyrus Asadi	A cock  mpleted cause of death (  , 2c E, T)  Pagintaria S	monice	mrd.#	-Zeq /1	menium	111111	
¥		ate	31. Date filed (Month, Day, Year) FEB 2 8 2007		ignature	AP				
*	Regist	rar	LED # 0 500/	ALMOND A	To GOD	SEP .				

DHMH 17 Rev 1/2001

ORIGINAL

		•	For <b>Amend Ite</b>	n 27 <sup>State o</sup>	f Marylan d <b>r., g86</b>	d, 02/22 4,02/22	rtment of H 3/0/dhb tificate of L	ealth and l Death	Mental Hygi	ene g. No. 200	7 06033
	Physici /Medic		1. Decedent's Name (First, Middle Dorothy Yukin	. ,	hiro				2. Date of Death	17, 200	3. Time of Death 5:45A M
)-	Examin	er	4a. Facility Name (If not institution Milford Manor						h	4c. County of Death  Baltimore	
	Funeral Director		575-16-3343	6. Sex 1 □ M 2 □ ★F	7. Age ( <i>In yr</i> s. <b>91</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 12,	rear)	Birthplace (State or Foreign Country)
	ryland thow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	r 28a-f s notified	Director	MD Baltin  10e. Street and Number	ore	Pil	kesvill	e 10f. Zip Code		10	g. Citizen of Wha	1 ☐ Yes 2 XNo
	h with		4204 Old Milfo	ord Road			2120	8		USA	
920	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ★Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	<sup>2</sup> ★No ve	11	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 1 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Black, V	American Indian, White, etc.
Maryland 21215-0036	ithin 72 ho ne. nan "natur e Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	ent's Usual Occupa kind of work done o OO NOT use retired	luring most of wo	rking 1	6b. Kind of Busin	ess/Industry
2	led w tygier her th		17. Father's Name (First, Middle,	I cot)		Waitr	ess	19 Mother's Nor	ne (First, Middle, M	Bakery	
ylanc	@ E O S	To Be	Kama Kaneshir	•				Kanato	Nakamot	,	
lar)	2 sho and I Is ma rauma		19a. Informant's Name/Relationsh	nip (Type. Print)		1	` `		ıral Route Number,	, ,	
	ages 1 and 2 should but of Health and Ment: If Item 27 Is marked		Ruth Wienke - d	aughter	20h F	119	Willow Besition (Name of	end Driv			MD 21117
Baltimore,	Pages nent of H int: If Ite		1 ☐ Burial 2 🙀 Cremation		State	cemetery, cren	natory or other plac	í i .		0c. Location - Cit	
를	T 5 E C		4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Funeral Service		Met	tro Cre	matory,  Name and Addres	Inc. 2/2	0/2007	Baltimor	e, MD
Ba	permit. Departr Importa any Inja once.		21. Signature of Funeral Service	teven H.	Willian	ns	Cremation 299 Frede	Societ	y of Mary ad, Balti	land, In	21228
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition			h. Do not ente	er the mode of dyin	g, such as cardia	or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,		(or as a conseq						
	nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):							
8760,	rate be executed only sician and the burial-transit	dical Exal	that initiated events resulting in death) Last	c	(or as a conseq	uence of):					
289	ifficate g physi as the l	edic		u						1	
P.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year		
rds, P	w requires that the d been signed by the should be detached	ρ	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did toba		te to the cause of death?  Probably 4 Munknown
al Records,	: The law re cate has bee page 2 sho	Completed	<i></i>	\					24a. Was an autopsy perform	utopsy prior to completion of cause death?	
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		ath (Check only one		
ō	Phys r this rral dii	-: To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	3 DOA	4 Mursing F	lome 5 ☐ Resider 28d. Describe hov		Specify)
O	th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Mon	th, Day Year)	Injury	Work	(? Yes 2 ∐ No		mjary occarroa	
Division or	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	oot be ined 28e. Place build	e of injury - At ho ing, etc. (Specif	ome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)	Examiner: On the b	e best of my kno easis of examina ner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the cau urred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
)	To the virthing comp.	Me	29b. Signature and title of certifier  MANUM W	rathemo			29c. License	number 05744		d. Date signed (A	Nonth, Day, Year)
	(1)		30. Name and address of person					isterston	n, MD- Z	1136	
	Sta Registr	_	31. Date filed (Month, Day, Year)		Registrar's Signa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #10c,16a-b,10a-c,22,perfH, 685 Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene (1)

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Lewis Keys February 19, 2007 2:14 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 940 Garden Drive Essex Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min Months 1**∑**M 2□F Yrs. 217-46-1441 60 Director Jan 20, 1947 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Essex 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 940 Garden Drive 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates: 166-70 filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ☐ Widowed 4 ☑ Divorced "netural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1111 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Programmer Computer h and Mental Hygier 7 le markad othar ti 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Lewis Gilbert Keys Margaret Simmons ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 Joan Keys/sister 17 Braker Court Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 6 1 ☐ Burial 2 **K** Cremation 3 ☐ Removal from State 22. Name and Address of Facility Prozedzinski, F.H., F.A. 1407 Factorn Ave. permit. Page Depertment of Important: if eny injury or once. 4 □ Donation 5 1 Other (Specify) in state Bayview Crematory 21. Signature of Funeral Service Licensee ROITald 5. Wade, Directo 21201 Essex, MD 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Artanias Claratic Cardia Vascular Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes certificete 1☐ Yes After this certification funeral director. or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 1 Natural 2 Accident 5 Pending investigation Injury death. 1 TYes 2 TNo iours efter death. neral Director: A filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours el To the Funeral D 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 1866 death (Item 23a) (Type, Print) Name and address of person who completed cause Trimble Hill CT. Lutherville, MD 31. Date file (Month, Day, Year) 32. Registrar's Signature State **FEB 28** 2007

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State of Marylan		artment of H			giene Reg. No. 00	7 06035	
d	Physici	an	1. Decedent's Name (First, Middle, La	King				2. Date of Dea	Day Y	ear 4 20 q. M	
100	/Medic Examin		4a. Fecility Name (If not institution, give Manor Care			4b. City, Town, or	Location of Dea		4c. County of	Death .timore	
1 -	Funeral Director		5. Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir	s. 8. Date of Birt	v. Year)	. Birthplace (State or Foreign Country) [aryland]	
	ryland show		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo					10d. Inside City Limits	
	the Ma 28a-f s	ecto	MD  10e, Street and Number		Baltir	nore			10g. Citizen of Wh	11√ Yes 2 No at Country?	
	h with 23a or	al Dir	1813 Eastern Ave	enue		21221			USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show empty injury or other treumatic event, the Micdical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Acred Forces? 1 23 Yes 2 No If Yes, Give Year or Dates: 43	.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? ( in, Mexican, Pue Specity:	Specify Yes or No no Rican, etc.)	Black,	American Indian, White, etc. White	
Maryland 21215-0036	ithin 72 ho	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done on DO NOT use retired	during most of w	orking	16b. Kind of Busin		
d 23	Hygier ther th	Cor	12 17. Father's Name (First, Middle, Last	)		manage		ame (First, Middle,	restara Maiden Sumame)	unts	
/Jan	uld be Mental rrked c	To Be	Oliver Cox R	ling			Elsi	e Edenfi	eld		
, Man	and 2 sho laith and I n 27 is ma er treums		19a. Informant's Name/Relationship ( Marlene Valchos/			ng Address (Street abilizer			, MD 212	20	
Baltimore,	Pages 1 nent of He ant: If Itan ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special Contents)	Removal from State		osition (Name of matory or other plac	ce)	Date	20c. Location - Ci	ty or Town, State	
Balt	permit. Departi Importi eny Inj		21. Signalure of Euneral Service Sice	Wade, Divector	r Si	altimore,	-		Baltimor	e Street	
	Physician		23a. Part 1. Enter the disease or con shock or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dear one cause on each line.						Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consec		0/)/-	, , ,	- C7    -	- 13		
47	outed id	Examiner									
8760,	cate be executed physician and the burial-transit	resulting in death) Last  Due to (or as a consequence of):  d.									
P.O. Box 68	he death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a	aldeath 3	⊒Ectopic pregnancy □ Other (specify) _	1		23d. Date Month		
	es tha igned be de	by	Part II. Other significant conditions	100		ute to the cause of death?					
Records,	The te h	Completed				24a. Was auto perfo	ormed? pri	ore autopsy findings available or to completion of cause of ath?  Yes 2 No			
Vital	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		0.1		eath (Check only o	one)		
ō	ling Phys ). After this tuneral dir	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injur	4 Nursing		dence 6 Other		
Division	or Attenter ter deat irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not learnined					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying P (Check duly pine) 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the timestigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)	
	To th Within To th	Me	29b. Signature and title of certifier	đ		29c. Licens	e number		29d. Date signed (	Month, Day, Year)	
•			Kywley Khoteys	MA		D00	60560		FEBRUAR .	14,2007	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type <b>R\√+&gt;1</b>	Print) NFUL K	20. HI	OR BAL	TIMURE.	MA	
200	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 8 2	completed cause of death (Ite 201 BACK Registrar's Sign	ture 4	orle)		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 24. 2007 FEBRUARY 5:00 P M FRANCES V. KOONTZ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) Months Days Hours Min 1 ☐ M 2 🗓 F Yrs. 1935 WEST VIRGINIA Director 236-50-0410 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show Item 27 is marked other then "neturel", or Items 23e or 28e-f shov other treumstic event, the Madical Exam har must be notified at 1 ☐ Yes 2X No Director GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 UNITED STATES 708 WASHINGTON AVE. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER MANUFACTURING 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill and Mental H Be MARY L. CRABTREE WOODROW KENNEY 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Item 27 708 WASHINGTON AVE GLEN BURNIE, MD 21060 JOHN F. KOONTZ / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> ö 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MARCH 1, Department of Importent: If eny injury or once. 4 □Donatjøn 5 □Other (Specify) 2007 GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PARK 21. Signatu 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21061 GLEN BURNIE, MD 421 CRAIN HWY. SE; 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to initiourate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached the 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? þ Division of Vital Records, funeral director, page 2 should be 2 1 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No after death death 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

N

DHMH 17 Rev 1/2001

IRA WEINSTEIN, MD
31. Date filed (Month, Day, Year)

2007 Jeneur St. Sy

2001 MEDICAL PARKWAY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carle

ANNAPOLIS, MD 21401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ANNA KREJCI FEBRUARY 25,2007 22:21 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** UPPER CHESAPEAKE MEDICAL CENTER HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-11-1916 9. Birthplace (State or Foreign **Funeral** Days 213-01-6430 1 ☐ M 2 🖫 F 91 Yrs. MARYLAND Director Usuat Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at MD HARFORD REL AIR 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1226 BEAR HALLOW COURT 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: Be Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME other 7 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 end 2 should be nent of Heelth and Mental JOHN KOUTNIK ANNA (STEINER) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth a JOSEPH J. KREJCI/HUSBAND 1226 BEAR HALLOW COURT permit. Peges 1 end Depertment of Heelth Important: If item 27 any injury or other tr 2002. BEL AIR, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 2-28-2007 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complete **Physician** Day /Medical Due to (or as a consequence of): Examiner SINUC Sequentially list corrollors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical the ettending for use es 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 2 ER/Outpatient 3 DOA this After thi 27. Many or of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide to Certifying Physician: To the best of my knowledge death occurred at the time. Jate and class and the Lothe course(s) and charges a state of December 1 December 1 December 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item, 23a) (Type, Print Inch, M.D. 2 . Bel Air MP North 31. Date filed (Monty, Day, Year) 32. Registrar's Signature State FEB 28 Registrar 2007

State of Maryland / Department of Health and Mental Hygiene 0 7 0 6 0 3 8

Certificate of Death

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			Decedent's Name (First, Middle, Las	1)				2. Date of Death Month		Year	3. Time of De	ath			
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	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of						
			MANDRIN HOSPICE			HARWOO			ANNE						
	Funeral Director		214-48-0131	7. Age ( <i>In yrs. last</i> 62	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 9 ,	Year) 1944 I	9. Birthp Coun PENNS	lace (State or Fitry)	oreign A			
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	Jeath Tre 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Vas Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-			an Indian,				
2	be filed within 72 hours after death with the Maryland Hygiene. d other then "neturel", or items 23a or 28a-f show do other then "neturel", or items 23a or 28a-f show event, the Moulcal Examinar must be notified at	by Fur	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	1	Tes, specify Cub	an', Mexican', Puerto Specify:	nicati, etc.)	Specify:	k, White, WH]					
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ORIGINAL

LOWRY, MARGARET

		-	For State Registrar	State of	Maryland /		artment of H tificate of L		d Mental Hy	giene () (	7 (	06041
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	/Medic Examin		4a. Facility Name (If not institution			NTER		LE RIV	/ER	4c. County	BALTI	
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	V		30. Name and address of person	NASERMA	709	12	Print) ASTERN	1 BL	54 VD, N	10-3	212	21 .
	Sta Regist		31. Date filed (Month, Pay, Vigar	8 2007 32	gistrar's Signatu	· A	ande					

State of Maryland / Department of Health and Mental Hygiene 06042 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** P MCCLUNG RICHARD 3:45-4 02 クチ 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Howard Columbia Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 [XM 2 □ F Yrs. Pennsylvania 78 Director 159-20-2638 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Directo Catonsville Baltimore Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21228 USA 2123 Rockhaven Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Martinal 2000. Black, White, etc. Armed Folloes: 1 XYes 2 □ No If Yes, Give Year or Dates: 1946-47 1 Never Married 2 Married White 1 ☐ Yes 21X No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Actor Film Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Parker Robert M. McClung 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2123 Rockhaven Avenue; Catonsville, MD 21228 Wife Lena Winstead McClung 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Entombment Dulaney Valley 3/2/2007 Timonium, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Tuneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonexquente of) Examiner ISCHEMIC COLITIS The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ STAPHYLOCOCCAL BACTEREMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed PLEURAL EFFUSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy CORONARY MATERY DISEASE 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide e Hospital 24 hours a E Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) Rang. Carus m.D. 02/27/07 2x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. CABRERA, M.D. 5755 CEDAR LANE, COLUMBIA, M.D. 21044 326 agistrar's Signature State Registrar

			_ For	State	of Maryla	and / Depa	artment of H	lealth ar	nd Mer	ntal Hygi	ene	
			1 - State Registrar			Ce	rtificate of	Death		Re	g. No 2 0 0	7 06043_
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)					2.	Date of Death Month	Day Ye	3. Time of Death
	Physici /Medic		Irma E. Mor	ris						ebruary	y 23, 200	7 5:20 A. M
	Examin	er	4a. Facility Name (If not institutio	n, give street and	number)		4b. City, Town, or				4c. County of D	
	4		Heartlands at			ra last hirthday	ELL10 If Under 1 Year	ott C		Date of Birth	1	oward
	Funeral		5. Social Security Number 216-05-3496	6. Sex 1 ☐ M 2 🔼 F		rs. last birthday) Yrs.	Months Days		Min. A	Month, Day,	Year) 9.	Birthplace (State or Foreign Country) Maryland
	Director		Usual Residence of Decedent		70					IPI II	, 1710	ilar y rand
	yland now		10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
	a-fst	냥	Maryland	Howard		Ellic	ott City					1 □Yes 2ĀNo
	or 28	Director	10e. Street and Number	n 1	# . o =		10f. Zip Code			10	g. Citizen of What	Country?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene, whatural" or items 23a or 28a-f show int, the Medical Examiner must be notified at		3004 North Rid				21043				USA	
	er de	Funeral	11. Marital Status	Armed	ecedent Ever in Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origii an, Mexican,	n? (Specify Puerto <b>R</b> ic	y Yes or No- an, etc.)		merican Indian, Vhite, etc.
20	s afte	by F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes	es 2 🔯 No Give r Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify:	White
2-003c	tura atura al Es		15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation			 16b. Kind of Busine	ess/Industry
2	nin 72 n "na Medi	plet	(Specify only higher Elementary/Secondary (0-12)	est grade complete	ed) e (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most o d)	of working	Ţ.		
7	d with giene er tha	Completed	12	College		I	lomemaker				Own Hom	е
and	be filed within 72 hours after death with the Marylar Hydjene.  4 other than "natural;" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle						,		faiden Surname)	
<u>  a</u>	Ment Ment arked aric e	흔	Christian J.	Eitemille	er			Cathe	rine	Cruetz	er	<u>.</u>
Mar	ss 1 and 2 should be filed v of Health and Mental Hygie i frem 27 is marked other t r other traumatic event, th		19a. Informant's Name/Relations	ship (Type. Print)			ng Address (Street					
			Christian John	Meyer	Nephew		Russell A	Avenue	; Woo		<del></del>	
0	ges 1 It of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation			cemetery, cre	osition (Name of matory or other place		/1/20		20c. Location - City	
Baltimor	t. Pa ntmen ntant: njury		4 □ Donation 5 □ Other (	-	10.5410		Crematory					le, Maryland
g D	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature Funeral Sprojec	censee	11000	2	Funeral H	lome of	f Cat	onsvil	le, Inc.	wab Witzke
		$\vdash$	23a Parti Enter the disease of	or complications the	NO129		1630 Edmo	ndson	Aveni	ue; Cat	tonsville	MD 21228 Approximate
			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause o	n each line.	Datii. Do 1100 011	ior the mode of dyn	19, 54511 45 50	ardiao or re	Δ	156155	Interval Between Onset and Death
ı	Physician / /Medical		disease or condition resulting in death)	a	_		= < > = > = >	C	110.	UVAS	CJCAR	MANY YEARS
	Examiner			Due	to (or as a cons	sequence or):						
às,		ē	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due	to (or as a cons	se uence of:						
V	uted d ansit	Examiner	Cause (Disease or injury that initiated events	<b>S</b> .								
, O	an an rial-tr	Exa	resulting in death) Last	Due	to (or as a cons	sequence of):						
0/8 8/90	the death certificate be executed y the attending physician and ched for use as the burial-transit	dical		d								
õ	ertifica ing ph	0 1	IF FEMALE:									
X Q Q	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Liv	outcome pf pre /e birth 2 ☐ F	etal death 3	Ectopic pregnanc	у			23d. Date of Month	delivery Day Year
	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		egnant at time o iknown	of death 5	Other (specify)					,
Ţ.	w requires that the de been signed by the should be detached		Part II. Other significant condit	ions contributing t	o death but not	resulting in the u	inderlying cause giv	en in Part I.		23e. Did tob	acco use contribut	e to the cause of death?
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ecord	v requ been shoul	Completed								24a. Was ar	24h Wer	e autopsy findings available
Ď Ľ	e la has je 2	du								autops perforn	y prior ned2 deat	to completion of cause of h?
		ပိ	25. Was case referred to medica	al				26 Place o	of Dooth (C	1□ Yes 2 Check only one		Yes 2□No
>		To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐Inpatient 2	P ☐ ER/Outpatie	nt 3 DOA Oth				nce 6 Other (\$	Spaciful
	g Physer this eral dii		27. Manner of Death	28a. Da	ate of Injury Month, Day Year	28b. Time o					w injury occurred	эреспу
0	Attending F r death. ector: After by the funera	atio	Z III Accident	igation	nonur, Day Tear	, injury	1	Yes 2 □ No	0			
UIVISION	if or Attend after death Director: , I in by the f	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be nined 28e. Pla	ace of injury - A uilding, etc. (Spe	t home, farm, st	reet, factory, office		28f.	Location (Str		r Rural Route Number,
5	ital or A rs after or al Direct led in by	ě										
	To the Hospital or within 24 hours aft To the Funeral D completely filled in	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To I Examiner: On the	the best of my lee basis of exam	knowledge, dea nination and/or in	th occurred at the till ovestigation, in my o	me, date and opinion, death	l place, and h occurred	due to the ca at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	the thin 2 the the thin 2 the	Med	one) 29b. Signature and title of certific	and m	nanner stated.		29c Licens	e number		- 20	2d Data signed (M	Ionth Day Voor)
	<b>₽</b> ₹ ₽ 8		29b. Signature and title of certific	10	1	10	0.00	250	44			2 co 3
l			On Alomo sed addesses	a who committee	Outpoort do the "	tom 93a\ /T	Print)		- /	1	013.73	, 200/
	10		30. Name and address of person	MINIO COMPleted C	ause of death (I	O S	YII OCA	FRE	coca	reic 1	20 4/8	
	Sta	ate	31. Date filed (Month, Day, Year	) 34	Registrar's Si	gnature	DALTIME	176	100	J 61	/	
	Regist		FEB 2 8	2007	Bine.	15 Ag	342)					r as stated. due to the cause(s)  fonth, Day, Year)

			State of Maryland / Den	partment of Health and Ment		•	011
			_ roi	ertificate of Death	Reg.	2007 00	044
	Physicia	an	1. Decedent's Name (First, Middle, Last)	N 1	ate of Death Jonth		of Death 27 PM
	/Medic	al	William Murray Murphy  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	by mary	4c. County of Death	~ / I M
	Examin	er	Baltimore Washington Med Ctr	Glen Burnie		Anne Arunde	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min.	ate of Birth Month, Day, Ye 3/06/1	9. Birthplace (Star	te or Foreign
-	Director		219-18-4566 79 Yrs. Usual Residence of Decedent	0	3/06/1	.927	MD
	aryland show	_	10a. State 10b. County 10c. City, Town or L				e City Limits  Yes 2 No
	the Ma	Director	MD Anne Arundel Rivier	a Beach	100	Citizen of What Country?	es 2 m 140
	3e or	I Dir	240 Glenwood Road	21122	109.	U.S.A.	
	ams 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Specify 'If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No-	14. Race - American Indian Black, White, etc.	,
30	s after	by Fu	1 Never Married 2 Married 1 Mayes 2 No 1945 - If Yes, Give 1946	1 ☐ Yes 2 M No Specify:		Specify: White	
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. It al Hygiene. It other than "netural", or Itams 23e or 28e-f show avent, the Medical Exertil at mail by multiped at	ted k	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b	. Kind of Business/Industry	
7	ithin 7 e. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)			
2	filed w Hygien othar ti	Col	12 Ins	Spector  18. Mother's Name (Firs		.G. & E.	
<u>'an</u>	should be nd Mental marked o	To Be	John J. Murphy	Ella V.	. Eden	field	
Maryland	2 sho and is m	·		ling Address (Street and Number or Rural Rou			
	1 and Health tam 27 other to		20a Method of Disposition 20b. Place of Disp	Alford Drive, Pas position (Name of Date		, MD 21122 Location - City or Town, State	)
ē			1 ■ Burial 2 □ Cremation 3 □ Removal from State	ven Mem Pk 02/24/		en Burnie,	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $G \cdot J \cdot G$	Sonce	Funeral Home	e, PA
n	8 Q E # 9			169 Riviera Drive,			
	5c*		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac or res	piratory arrest,	Approxir Interval I Onset ar	Between nd Death
	Pnysician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	nal Failure			
e	Examiner		Sequentially list conditions, b. Wywk a le	mid			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	least Block			
o Î	be executed sician and burial-transit	Exal	that initiated events c				
8760	ate hy:	dical	d				
X Q	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box.	death e atter	Physician/Med	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day	Year
J Ö	The law requires that the de tie has been signed by the a bage 2 should be detached i	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underhier eaung given in Dect I	23a Did tobaco	to use contribute to the cause	of death\$
ds,	uires the signer of the color o	d by	Part II. Outer significant conditions continuously to death out not resulting in the	underlying cause given in Parts.		2 No 3 Probably 4	. /
ecords,	aw require s been si s should l	Completed		2	24a. Was an	24b. Were autopsy findin	gs available
r		Com		1	autopsy performed Yes 2		or cause or
Vital	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che			
ō	Phy this	7: To	27. Mann of Death 28a. Date of Injury 28b. Time	#IL 3 DOA 4 Nursing Home	5  Residence Describe how in	6 ☐Other (Specify)	
ioi	Attending death. ctor: Afte y the fun	atlo	1 Vatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	il or Attending Patter death. Diractor: After t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. L	ocation (Street City or Town, St	and Number or Rural Route N ate)	umber,
	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and d	ue to the cause	(s) and manner as stated.	
	he Ho in 24 h he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at	the time, date a	and place, and due to the caus	
	To the I	Ž	29b. Signature and title of certifier & William M.	D 29c. License number 5	29d. 1	Date signed (Month, Day, Year	2007
	intl		30. Name and address of person who completed cause of death (Item 23a) (Tues	Print), A	4	O MIN	71.577
_	10		30. Name and address of parson who completed caute of death (Item 23a) (Type Teorge T. Wicks M.D.; 30	Ol Hospital Drive,	Glen	Durney 110,	21161
	Sta Registr		31. Date filed (Month, Day, Year)	<i>d</i> ,			
	negisti	qI	FFB 2 8 2007				

DHMH 17 Rev 1/2001

Murphy, William

			For State Registrar	State of Marylan		ittliera of f			giene Reg. No. 🤈 🗍	0.7	061	01.5
F	Physici	an	1. Decedent's Name (First, Middle, Last	,				2. Date of Dea Month	ath Day	Year	3. Time of	Death
Į.	/Medic	al	Pearl Regina Mero			41. O'L. T	-1 1 D1		y 24 2007		8:25	A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give Stella Maris	street and number)		4b. City, Town, or Baltimore		(n	4c. County	imore		
-	Funeral		5. Social Security Number 6. Se 213–44–9942	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs			9. Birthpla	ace (State of	r Foreign
S. S.	Director		<del>213 03 1822</del> 1	<sup>™ 2</sup> F 99	Yrs.	Months Days	Hours Min.	December December		Maryla		
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside Cit	ty Limits
	Maryla f sho	rot	Maryland Baltimore		ite Mars						1 ☐ Yes	-
	r 28a-	Director	10e. Street and Number	e j Wil	TOS MATS	10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	X
	th with		10816 Red Lion Road			21162			USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America k, White, e		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		i⊡Yes 2 <b>√√X</b> No	Specify:		Specify			
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	edk	15. Decedent's Edu	ıcation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Bu	Whit	-	
215	within 72 iene. than "na he Medi	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give life. I	kind of work done on NOT use retired	during most of wo d)	rking			,	
2	filed wit Hygien ther tha	S	10	N/A	Homema	ker			Houseke	<del></del>	Own Home	3
pu	be filed ntal Hygi ed other event, tl	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Surnam	ne)		
Σ	should be ind Menta s marked umatic ev	2	Francis Young  19a, Informant's Name/Relationship (Ti	(ne Print)	19b Mailin	g Address (Street	Anna Cha		City or Town	Ctata Zin i	Carlal	
Maryland	nd 2 s Ilth ar 27 Is r trau		William V Mercer	pe. r iing	1	Red Lion F					Jode)	
re,	of Hea		20a. Method of Disposition		lace of Dispos	sition (Name of natory or other place	i	Date	20c. Location -		vn, State	
m	Pages nent of I int: If ite		1 🔀 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,	removal from State		m. Gdns. Ma	·	7	Bel Air,	Maryla	and	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licens	iee		. Name and Addres	,	m U/\	50 Belair			
			23a Part1 Enter the disease	lications that caused the death				King	gsville, N		d 21087 Approximate	
	Physician		23a. Part1. Enter the disease, somp shock, or heart failure. List only o Immediate Cause (Final				g, odo, ao odi dia	o or respiratory an	1631,		Interval Bety Onset and D	veen
)	/Medical		disease or condition resulting in death)	a. END STAGE DI  Due to (or as a consequ		A						
	Examiner		Conventially list and ditions	b	,							
	p tig	iner	if any, leading to immediate	Due to (or as a consequ	ience of):							
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):							
68760,	icate be executed physician and s the burial-transit			a secto (or as a consequ	ienee oi).							
		ledical		0.								
Вох	leath certifi attending I for use as	M/us	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1□Live birth 2□Fetal		Ectopic pregnancy	,		23d. Dat	e of deliver	y	
	the death certify the attending ched for use as	Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown		Other (specify)		-	Moi	nth [	Day Y	'ear
P.O.	that the de ned by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions co	ntributing to death but not resu	Iting in the ur	idedvina cause aive	on in Part I	23a Did to	bacco use contr	ibute to the	anuna of de	noth?
Records,	e ig	d by	Tank out of organization of out	initiality to accur partiet recu	ang ar are ur	denying cause give	strill rare,		es 2 No			
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or Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	1  Yes ath (Check only or	21	∐Yes 2	2□ No	-
<u>r</u> <	S S I	ToE	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe		lome 5 ☐ Resid		er (Specify)	HOSP1	[CE
n o	ng ffe		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?		ow injury occurr			
isio	Attending r death. ector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	mo form etro		Yes 2 ☐ No	ODF Loophing (C	Ann a h a m of 8 to come to	D	<u> </u>	
Division	after of Direct of in by	Certification:	4 Homicide determined	building, etc. (Specify	nie, iaim, sire	set, factory, office		City or Tow	treet and Numbe n, State)	er or Hurai	Houte Numi	er,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, co	cause(s) and ma date and place, a	nner as sta and due to t	ited. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed	(Month, D	ay, Year)	
			1-			1)	1372		2/2	26/0	7	
	20		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type, I	Print)						
	0	<b>.</b>	DR. TARIQ MAHMOO  31. Date filed (Month, Day, Year)	D 2300 DULANE 32. R	Y VALI	EY RD.	TIMONIUM	, MD 210	93			
	Sta Registr		FEB 2 8 20		K A	beet						

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8:25 а.ш.

FEBRUARY 24, 2007

PEARL MERCER

			For State Registrar	State of M	laryland / De	partmer <i>ertificat</i>				ental Hy	giene Reg. No.	007	06046
۱	Physici	an	Decedent's Name (First, Middle, L     C	-						2. Date of De Month	Day		
	/Medic	al	4a. Facility Name (If not institution, g	rah Mae Ma		4b. City.	Town, or	Location of		ebrua		2007 County of De	20:00P M
	Examin	er	St. Agnes Hosp				1tim					N/A	
	Funeral Director		216 36 8671	Sex 7. A	ge (In yrs. last birthd 65 Yrs	Months	Days	If Under Hours	Min.	Date of Bi (Month, Da )ct. 1	rth av, Year) 4, 19		Birthplace (State or Foreign Country) aryland
	land Dw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	Many a-f sho	tor	Maryland Balt	imore	Haleth	norpe							1 ☐ Yes 2 😿 No
	or 28s	Olrec	10e. Street and Number	B 1 1 .	1.	10f. Zip					-	en of What	Country?
	s 23a	eral	4130 Annapolis			13 Was Door	212		igin? (Speci	the Voc or Ne		J.S.A.	nerican Indian.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural; or Items 23e or 28e-f show other treumatic event, the Medical Evening Inernitied at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 ☐ Yes		n, Mexicar		can, etc.)		Black, W	hite, etc.
2-0	72 ho	eted	15. Decedent's (Specify only highest of		16a. De	ecedent's Usu live kind of wo	al Occupa	ation during mos	t of working	1	16b. Kin	nd of Busine	ss/Industry
21215-0036	12 should be filed within "n and Mental Hygiene." I's marked othar than "reumatic evant, the Me	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+1	itress	se retired						Service
Maryland	ould be fill Mental H arked ott	To Be	17. Father's Name (First, Middle, La. Erne	est Berger					uby 0	First, Middle  Neil	, Maiden S	Sumame)	
	1 and 2 sho Health and tem 27 Is mu other treum		19a. Informant's Name/Relationship Charles Martin			ailing Address  O Anna							, Zip Code) , MD. 21227
Baltimore,	Pages 1 and 3 nent of Health ant: If Item 27 ury or othar tru		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			sposition (National Communication (National Communication)	other plac	e) TARY	2/28				or Town, State
Balti	permit. Pages Department of Important: If II any injury or c		21. Signatu o Funeral Service Lic			112.5							ce, P.A. yland 21225
			23a. Part1. Enter the disease, or ed shock, or heart failure. List on	mplications that cause	d the death. Do not							,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)		TIC SHOCK								Onset and Death 2 Weeks
	/Medical Examiner		resulting in dealtry		s a consequence of):								2.16.11
	p H	ner	Sequentially list conditions, if any, leading to immediate cause. El to Underthing Cause (Disease or injury	D	HEMIC COL s a consequence of):								3 Months
/_	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):								
8760,	icate be ex physician s the burial	dlcal		d									
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 ⊟Ectopic pi 5 ⊡ Other (sp					23	3d. Date of o	lelivery Day Year
	uires that signed b ild be deta	by	Pan II. Other significant conditions Atherosclerot	-	_	, ,	ause give	en in Part I.		_	tobacco us Yes 2 □		to the cause of death?
Records,	The law requirate has been spage 2 should	Completed								24a. Was auto	psy ormed?	prior t death	
of Vital R	ician: T certificate rector, pa	0	25. Was case referred to medical					26. Place	of Death (	1 √ Yes Check only	2□No one)	15)	s 2□ No
) t	d is	To B	examiner? 1 ☐ Yes 2 D No	Hospital: 1 Inpat				4 🗀 IVU	ırsing Home	5 ☐ Resi	dence 6	□Other (Sp	pecify)
	Jing After fune	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Da	ury 28b. Tim ay Year) Inju	e of 2 ry M	28c. Injury Work	rat ⊲? Yes 2 🔲		d. Describe	how injury	occurred	
Division	or Attendent titer deati Director: in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	iju <b>ry</b> - At home, farm tc. <i>(Specify)</i>					f. Location ( City or To		Number or	Rural Route Number,
	To the Hospital or At within 24 hours after or To tha Funarel Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the besi aminer: On the basis and manner s	of examination and/o	eath occurred r investigation	at the tim	e, date an pinion, dea	nd place, and th occurred	d due to the at the time,	cause(s) a	and manner place, and d	as stated. ue to the cause(s)
	ro the vithin to the comple	Mec	29b. Signature and title of certifier	and mainer 3	idieu.	29	c. License	number			29d. Date	signed (Mo	nth, Day, Year)
	> - 0		ha.				D52	540			Febru	ary 2	2, 2007
	6		30. Name and address of person wh Thomas J. Ene				Balti	more,	, MD 2	21229			
4.	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	A west	6						

07-01554 Selfia Medina Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Redistrar	e of Death	-intai riyg		1. No. 2007	0604
Physicia edical Exami	40 07	1. Decedent's Name (First, Middle,Last) Selfia Medina			Date of Death Month ebruary 25	Day Year	3. Time of Death 0133 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		Column 2	4c. County of Death	
		South Bound 295, South of 175	Annapolis Junctio			Anne Arundel	
Funeral Director		5. Social Security Number 463 79 5726  Compared to the second of the sec	y) If Under 1 Year If Un Months Days Hou	ure Min	Dec 22	(MM/DD/YYYY) 9. Birt Foreig Cou	
any		10a. State 10b. County 10c, City, Town or L	ocation				10d. Inside City Limits
land f show	tor		Angelo				1 XXYes 2 No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 619 E. 35th Street	10f. Zip Code 76903			Citizen of What Cour United Stat	
leath wi	Funeral	11. Marital Status  1 XX Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 XXNo	<ul> <li>Was Decedent of Hispanic O If Yes, specify Cuban, Mexica</li> </ul>			14. Race - Americ White, etc.	an Indian, Black,
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	XX Yes 2 XXIII specif			Specify:	White
2 hours "natur	ted	15 Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	edent's Usual Occupation (Giv ng most of working life. DO NO	ve kind of work OT use retired)	done	16b. Kind of Business/Ir	ndustry
036 ithin 72 re: r than 1edical	ompleted	12 Car	e Giver			Day Care	e Center
21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Jaime Medina	Cı	ristina	Barto	aiden Surname) <del>n</del> Juarez	
D 21 should and Me 7 is ma	T <sub>0</sub>		ailing Address (Street and No. 9 E. 35th Stre				
Baltimore, MD bermit Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati		20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery, or other place)			20c. Location - City or	
MOF Pages nent of nnt: If		A Bullat 2   Clettlation 3   Removation State	y Cemetery Mai	rch 2,	2007	San Angelo	o, Texas
Balti permit Departn Import injury		21. Signature of Funeral Service Licentee  1. 100 153	22. Name and Address of Faci Alexandria Fei	ility Lee	Funera	1 Home, Inc	
Physician /Medical		25a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.					Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Head and Neck Injuries  Due to (or as a consequence of):					Death
	L	Sequentially list conditions, b					
	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C.					
My de		events resulting in death) Last  Due to (or as a consequence of):  d.					
760, Example 760, Totale be executed the burial - transit	edical	UNPENDED AMENDED 18, perFH, g865,	3/6/07 TT				
3760 ficate t g physi s the bu	Σ	IF FEMALE: 23b. Was decedent pregnant in the		opic pregnancy	,	23d. Date of delivery Month D	ay Year
of Vital Records, P.O. Box 68760, imp Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Physician/	past 12 months?  1 Yes 2 No 9 V Unknown  1 Live birth 2 Pregnant at time of death 5	Other (Specify)	, and programme,			-,
O. B at the d d by the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	Part I.	23e. Did tob	acco use contribute to t	he cause of death?
S, P. uires th	ed by			-		2 No 3 Prob	
cords aw requas been 2 shoul	Completed				24a. Was ar autopsy perform	prior to c	opsy findings available ompletion of cause of
Rec : The lificate lificate lift.		DE Was seen referred to medical	26 Diego of Dog	oth (Chook only	1 🗸 Yes 2		s 2 No
Vital ysician his cert directo	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: I Inpatient 2 ER/Outpa	26.Place of Dea			esidence 6 🗸 Other	Scene
Division of Vital Records, P.O within 19 the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed be completely filled in by the funeral director, page 2 should be detact	tion: To	27. Manner of Death         28a. Date of Injury         28b. Tim           1 Natural         5 Pending         Feb 25, 2007         0114 hr	e of Injury 28c. Injury at Wo	IPa		w injury occurred uto collision	
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 M Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / High			or Town, Sta	reet and Number or Ru ate) th of Route 175, Ann	
ne Hosp n 24 ho ne Fune letely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and	place, and due	e to the cause	(s) and manner as state	d. e cause(s)
To the within To the comp	Medical	and manner stated  29b. Signature and title of certifier	29c. License numb			29d Date signed (Mor	
		Jasker Felel Mio	O.C.M.E.			February 25, 200	7
8		30. Name and address of person who completed cause of death (Item 23a)					
		6	111 Penn Street, Baltin	more, MD 2	1201		
Segrie	tate	LLD 7 × 2007   200 a 276 273	marke 8				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20b State of Maryland / Department of Health and Mental Hygiene Per FH G865 3/14/07 HH Reg, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb 20, 2007 Physician Margaret McCarthy Marsh 6:32 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 30,1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2₩F Boston, MASS 031 01 7147 89 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Charles Waldorf 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 2004 Wingate Court #5 20602 United States 23a death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter ☐ Yes 2√ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed by White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Printing Office Elementary/Secondary (0-12) College (1-4or 5+) Staff Clerical Fed Gov't 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John McCarthy Sullivan Annie ပ္ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Ford (Executor) 17809 Barney Drive Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 9,2007 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot MXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery (UNK) 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 Cilla ( Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterio sclaruti **Physician** heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) vision or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No ueaun? 1∐Yes 2∐No 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: № Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🗐 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide Hospital or filled in 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor **To the Fune** completely fi (Check only the 29b. Signature and title of entifie 29c. License number 29d. Date signed (Month, Day, Year) 1- James in

State Registrar

DHMH 17 Rev 1/2001

11701

2. Registrar's Signature

Livington Road, Fort WASHington mony/md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM T. JANNER MO

FEB 2 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 26, Alexander Robert Miskiel 2007 4:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 118 Conestoga Road Middle River Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 □ M 2 □ F 60 216-48-2701 1946 June 27, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 □Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Conestoga Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Import and Export 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Miskiel Jean Kowalczuk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Miskiel (wife) 118 Conestoga Road, Middle River. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 3/1/07 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) F-CUTE Myocossial 10 MIN Due to (or as a consequence of): Atheroscieros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 TYes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ္

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-transit and a physician the for use ed by the a cate has been signed, Completed certificate director. Be Certification: To funeral After t 24 hours after death Funeral Director: filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier (Check only one)

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of cortifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

Parante MD

State Registrar

Medical

31. Date filed (Month, Day, FEB 2 8 2007



To the I within 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 2007 Month **Physician** BARBARA GARRISON MOSBERG 12:15 pM February /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Roland Park Place Baltimore City 8. Date of Birth **1925** (Month, Day, Year) Jan 5, <del>1920</del> If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Days 82 Yrs. Director 218-52-2532 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r then "neturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 No Directo Maryland N/ABaltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 830 West 40th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. If them 27 is marked other then "neturel", or iten eny injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Shermer Garrison, Jr. Eloise Ε. ပ Peach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Mosberg, III (Son) 544 Bay Green Dr., Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Lorraine Park Cemetery 3/2/2007 Baltimore, Maryland 21. Signatura of Funeral Service Rice/see
Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pulmonary **Physician** OBSTYLCTIVE Chronic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete hes been sign, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes 1 | Yes 2 1 1√0 : After this certification at the section of the section. To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ompletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Moulli Owno 035102 February 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHIMORE MAVYLAND 830 NEST Forthieth Strut Don m.D

State Registrar 31. Date filed (Month, Day, Year)

32 registrar's Signature

		1 - State Registrar	State of Maryland		rtificate of		nentai n	ygien <u>e</u> U Reg. No.	UI	0605
Physici	an	1. Decedent's Name (First, Middle, La					2. Date of I	Death Day	Year	3. Time of De
/Media	cal	THOMAS CONV			W 02 T		Febru			6:30A
Examir	ner	Presbyterian Home	of Maryland		Towson			Ва	y of Death ltimo	
uneral irector		5. Social Security Number 212-14-6746  Usual Residence of Decedent	7. Age (In yrs. la	rst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	April	8, 1922	9. Birthp	lace (State or Fo
how		10a. State 10b. County	10c. City	Town or Lo	cation				1	0d. tnside City L
r 28a-f ehow Incitited at	Director	Maryland Baltimo	re Tows	on	10f. Zip Code			10g. Citizen of	Mh-A O-	1 Tes 2
23e or	ra! Di	400 Georgia Court			21204			US		itr <b>y</b> ?
er, or items Examiner m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 TWo If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	No- 14. Ra Bla Speci	ce - Americack, White, of	
edical	Completed	15. Decedent's E (Specify only highest gra	de completed)	16a. Deced	ient's Usuat Occup kind of work done	nation during most of worki	ng	16b. Kind of E	Business/Ind	dustry
other than	E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		Attorney				Law	/
oth Vent,	Be C	17. Father's Name (First, Middle, Last,			No corne	18. Mother's Name	(First, Midd	le, Maiden Surna		
harked hatic e	ToE	Thomas Conway Mat				Josephi				
127 le n er traun		19a. Informant's Name/Relationship (Conway K Matthews	Type, Print) Son	19b. Mailir 116	g Address (Street Castletov	and Number or Rura VN Road Ti	al Route Num .mon i un	ber, City or Town 1 Marylar	, State, Zip 1d 210	<sup>Code)</sup> 193
Important: if Item 27 is marked other than any injury or other traumatic event, tha M once.		20a. Method of Disposition     X Burial 2 □ Cremation 3 □    Donation 5 □ Other (Specif.	Removal from State	netery, cren	sition (Name of natory or other place nt Cemete	(e)	oate '07	20c. Location		wn, State
Import any Inj once.		21 Signature of Funeral Service Licer	m lender	22	. Name and Addres	ss of Facility Mitc 6500 York F	chell-Wi Road Bal	edefeld Fu timore, Ma	meral l	Home Inc
sician edical		23a. Part1. Enter the disease, or comshock, or heart faiture. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseque	)~~ 7	of the	g, such as cardiac o	r respiratory	arrest,	1	Approximate Interval Between Onset and Deat
miner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyping Cause (Disease or injury			<del>-</del>					
lysicien and ne burial-transit	8	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):						
ned by the attending physical detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnand 1□Live birth 2□Fetat d 4□Pregnant at time of dea 9□Unknown	eath 3	Ectopic pregnancy Other (specify)				te of deliver	y Day Year
signe d be d	ρ	Part It. Dther significant conditions o	ontributing to death but not result	ing in the un	derlying cause give	en in Part I.		tobacco use cont		e cause of death
ete has page 2	Completed						24a. Was auto perf 1 Yes	ormeg?	Were autop: prior to com death? 1 \( \text{Yes} \) 2	sy findings avail- pletion of cause
certificata rector, pag		25. Was case referred to medical examiner?				26. Place of Death			103 2	22010
shis di	၉	1 Yes 2 No	Hospitat: 1 ☐ Inpatient 2 ☐ EF	?/Outpatient	3□ DOA Othe	or: 4, S Nursing Hom	ne 5∐Res	idence 6 □Oth	er (Specify)	
fter	Certification:	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	8b. Time of Injury		/es 2□No		how injury occurr		
		4 Homicide determined	building, etc. (Specify)				City or To	(Street and Numb wn, State)		
To the Fune completely III	Medical	29a. Certifier 12 Certifying Physics (Check only one) 2 Medical Example 19 Medical Exampl	iner: To the best of my knowle iner: On the basis of examination and manner stated.	adge, death n and/or inv	occurred at the time estigation, in my op	e, date and place, dr inion, death occurre	nd due to the d at the time,	cause(s) and ma date and place,	inner as stat and due to t	led. he cause(s)
# Z	2	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, D	av. Yearl

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kennith in Green in 670 W, Charles St., St. te 4/05 Bilthor, no 2/204

31. Date filed (Month, Day, Year)

32. Repetrar's Signature

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				Pleas						-	Are Legib	le.
			For State Registrar		State	ot Maryla		artment of l			giene Reg. No. 🤈 🕦	07 06053
	Physic /Medi		1. Decedent's Na	me (First, Middle Long Net		-				2. Date of De		3. Time of Death Year 2007 8:55 PM
	Examí	ner			give street and nuens at Fr		ip Heig	4b. City, Town, o	cr Location of Deat		4c. County o	f Death gomery
	Funeral Director		5. Social Security <b>241-12</b>	-9303	6. Sex 1 M 2 ☐ F		rs. last birthday, 2 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.		th 0/1914	9. Birthplace (State or Foreign Country)
	yland how at		Usual Residence 10a. State	10b. County		10c.	City, Town or L	ocation				10d. Inside City Limits
	the May 28a-f sl	ector	MD  10e. Street and N		gomery		Chevy C				10 000	1 □Yes 2 No
	th with 23a or ust be r	al Dir		riendshi	p Blvd.			10f. Zip Code 20815	5-		10g. Citizen of Wr	at Country?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	. 4	rried 2□ Marri	Armed F	edent Ever in orces? 2 No ive Dates: WV	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Stan, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	14. Race Black,	American Indian, White, etc. White
15-0	"natur	leted	(Sp	15. Decedent ecify only highes	s Education t grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor	rking	16b. Kind of Busi	ness/Industry
2121	d withir giene.	Completed by	Elementary/Sec	condary (0-12)	College (	1-4or 5+) <b>5+</b>		orney	(a)			
Maryland	ould be file Mental Hy Iarked othe	To Be (		Eugene	Newsom				Annie	Laurie L		
	und 2 sh alth and 27 Is rr er traurr		19a. Informant's I Linda	Name/Relationsh Silva/Dat			19b. Maili 555	ng Address (Street 55 Friend	and Number or Ruship Blv	<i>iral Route Numb</i> <b>d. Chevy</b>	er, City or Town, Si Chase,	tate, Zip Code) MD 20815-
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra				3 □Removal from		cemetery, cre	osition (Name of matory or other place eake Crem		Date Feb 27 2007	20c. Location - C	ity or Town, State
Balt	permit. Departr Importa any inje		21. Signature of	Funeral Service L	icensee	mo135	8 2	2. Name and Addre Rapp Fune 933 Gist			ervices ng, Maryla	and 20910-
1200,	Physician and bhysician and sthe burial-transit	ical Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or condition resulting in death  Sequentially list of it any leading 1.1 cause. Enter Uncause. Enter Uncause (Disease othat initiated even resulting in death)	on ditions, minute its	b. Due to	caused the depart line.  WMOY (or as a consider of the consideration of the considerati	equence of):	ter the mode of dyir	ng, such as cardiad	c or respiratory al	rrest,	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and nage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months? □ No		birth 2□Fe nant at time o	etal death 3	Ectopic pregnancy	У		23d. Date of Month	
	w requires that been signed b should be deta	þ	Part II. Other sign	ificant condition	ns contributing to d	eath but not re	esulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?  ☐ Probably 4 DUnknown
Division or Vital Records,		Be Completed	25. Was case refe						26. Place of Dea	1 Yes	prior prior dea 2 No 1 □	re autopsy findings available or to completion of cause of ath? IYes 2 ☐ No
or	this al dir	၉	1 ☐ Yes 2 27. Manner of Dea	No	28a. Date	of Injury	ER/Outpatier		4 Nursing H		lence 6 Other	(Specify)
ivision	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Natural 2  Accident 3  Suicide 4  Homicide	5 ☐ Pending investiga 6 ☐ Could no determin	ot be 28e. Place	th, Day Year) of injury - Ating, etc. (Spec	Injury home, farm, str cify)		ƙ? Yes 2 □ No		Street and Number	or Rural Route Number,
Ω	Hospital of the safe	edical Cer	29a. Certifier (Check only one)	Certifying	xaminer: On the b	asis of examil	nation and/or in	vestigation, in my o	pinion, death occu	, and due to the orred at the time,	cause(s) and mann	d due to the cause(s)
<b>.</b>	To the within 2 To the complet	Med	29b. Signature and		and man	ner stated.	Gemi	29c. License	e number	2	29d. Date signed (#	Month, Day, Year)
11	tar	-	30. Name and add	lress of person w	ho completed caus	se of death (Ite	em 23a) (Type,	Print)			_ 20	2007
	Sta Registr		Cynthia 31. Date filed (Ma	Th. WI	2007 33 B	legistrar's Sign	3.55 P	ccard	Dr. Ste.	100 Ro	ckville	Month, Day, Year) - 2007 - 1020850
DHI	MH 17 Rev 1/20						8.55					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 18 per fb 9865 3-9-07 vt.
State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 6:45 AM M /Medical Dolores Lorrine Noto February 25, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1721 H Chrisemmett Court Forest Hill
If Under 24 Hrs. 8. Harford 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🛣 F Months Yrs. Director 79 214-22-6906 08/01/1927 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ANO Director MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1721 H Chrisemmett Court 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates; 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Caucasian ģ Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be \_ Hughes Cox ပ Louis Lorraine Highes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Mueller/Daughter 1721 H Chrisemmett Court Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Feb 27 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2007 Beltsville, Maryland 21. Sigrature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pharynjea Physician Wasi /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hasl autopsy certificate ha 1∐ Yes R Z No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 25 No Other: ို 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ N this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Certification: Injury at Work? 28d. Describe how injury occurred After 1∕⊒Natural 2 ☐ Accident 5 ☐ Pending investigation after death.

I Director: Al 1 🗌 Yes 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the

Registra

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Au -

31. Date filed (Month, Day, FEB 2

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2007

69 65

2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 2 8 2007

nd address of person who completed cause of death (Item 23a) (Type, Print)

10 NONTH

Registrar's Signature

KOTLER

Medical

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D50500

29d. Date signed (Month, Day, Year)

GREENE STREET BALTIMONE MANY/and 21201

			For State Registrar	State of Marylar		irtment of H			giene .	0.7	06055
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea		J 1	3. Time of Death
	Physici		Iris	Pauline		Penman	1	PERPUA	PY 27	Year 2007	7.50 PM
	/Medio Examir		4a. Facility Name (If not institution, give	e street and number)			or Location of Dea	th	4c. County	of Death	
			BATIMORE LOASHIN	CTON MEDICAL	(ENTE	Z CIE	N BURN	HE	ANNI	EAT	PUNDEL
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v Year	9. Birthpi Coun	lace (State or Foreign
	Director		100-12-0027	□M 2□XF 93	Yrs.	World Days	TIOUIS WIII	Nov. 26	1913	Penn	<u>sylvania</u>
	pur *		Usual Residence of Decedent  10a, State 10b, County	10c C	ity, Town or Lo	cation				1	0d. Inside City Limits
	ed at	5	· ·							'	1 ☐ Yes 2 🖫 No
	28a-1	Director	PA Columbia		Bloomsb	10f. Zip Code			10g. Citizen of V	Vhat Cour	
	ours after deeth with the Maryle ral', or items 23a or 28a-f ehov Examiliar mant be notified at	ᄒ	212 West Pine Av	/o Apt 5		1781	5		USA	mai coun	uy:
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V			Specify Yes or No		e - Americ	an Indian.
(0	riter	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo	1		an, Mexican, Puè	Specify Yes or No- rto Rican, etc.)	Blac	k, White,	
93	urs a	<u>م</u>	3 → Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☑ No	Specify:		Specify	:	white
0-0	within 72 hours after deeth with the Maryland ane. Than "natural", or items 23a or 28a-f ehow he Maryleal Examiner mant be notified at	Completed	15. Decedent's Ed (Specify only highest gra	fucation	16a. Deced	ent's Usual Occup	pation	orking	16b. Kind of Bu	siness/Inc	dustry
21	en en	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire	d)	Jiking			
2	ygien yerth t, the	Co	12		Cas	hier	1				store
온	tal H d oth	Be	17. Father's Name (First, Middle, Last)		C			ime (First, Middle,			
200	2 should be filed within and Mental Hygiene. is marked other than reumatic event, the M	မှ	Peter		Savage		Tress			(ling	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hour Heelth and Mental Hygiene. Item 27 is marked other than Instural other treumatic event, the Mudical E	1 8	19a. Informant's Name/Relationship (19 Marlene Pegg	daughter				Paraden			Code)
_	1 an Heeli em 2 ther		20a. Method of Disposition	20b.	Place of Dispo:	sition (Name of		Pasadena	20c. Location -		nun State
) <u>p</u>	Pages net: If it iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory or other pla				•	WII, Glate
Baltimore,	artme artme ortani injury		4 □Donation 5 □Other (Specify 21. Signature of funeral Service Licen	1	nton Ce				Benton F		D .
Ba	permit. Pages Department of Important: If it eny injury or of once.			# 1	-	3111 M	lountain	allings Road Pas	runeral	Home	P.A.
			23a. Part1 Enter the disease, or com	plications that caused the dea	th. Do not ente					/ 211	Approximate
	Obverieien.		shock, or heart failure List only	one cause on each line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	nuence of):					_	
	Examiner				1						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
3.	cuted nd ransii	Examiner	that initiated events	C							
0	e exe ien ar urial-t		resulting in death) Last	Due to (or as a consec	quence of):						
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9	e as I	Mec	IF FEMALE:								
Вох	ath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet:	al death 3 🗆	Ectopic pregnance	y		23d. Date Mor	e of delive	ry Day Year
o.	the a	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at time of a 9 ☐ Unknown	death 5∟	Other (specify)					
σ.	The law requires that the dite hes been signed by the rage 2 should be detached		Part II. Other significant conditions o	ontributing to death but not re	sulting in the ur	ideriving cause giv	en in Part I.	23ø. Did to	bacco use contr	ibute to th	e cause of death?
ds,	sign d be	d by		•		, , ,		1 🗆 Y	res 2□No	3 🔲 Proba	ably 4 🗗 nknown
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of Vital Record	The lay sete hes page 2	Completed						autop perfor	rmegi? p	rior to con leath?	npletion of cause of
ā		ပိ	25. Was case referred to medical				Of Diago of De	1 ☐ Yes		☐ Yes	2 No
5		To B	examiner? 1 ☐ Yes 2 No	Hospital: 2 atient 2	] ER/Outpatien	3□ DOA Oth		Home 5 Resid		or /Specific	·1
	g Phy er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injui	y at		ow injury occurre		/
ō	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		Injury	M 1	Yes 2 No				
Division	or Atteno after death Director:	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, stre	et, factory, office		28t. Location (S City or Tow	Street and Numbern, State)	or Aural	Route Number,
۵	ital or A rs after ra! Dire led in b	Cer									
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	ical	(Check only 2 Madical Exan	ysician: To the best of my knowner: On the basis of examination	owledge, death	occurred at the til	me, date and plac	e, and due to the durred at the time.	cause(s) and man	nner as sta	ated.
	To the within 2 To the Complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens					
	7. ≱ † §	-	N. C.	M-	/w			9	29d. Date signed		
			30. Name and address of person who	completed course of trail "	m 22c) /T == 1	Prior)	23.4		Callan	7	-10001
	6			on Nother	l Dr	ee ge	en Pou	q f	ma a	016	1 "
	Sta		31. Date liled (Month, Day, Year)	32 Registrar's Sign	ature La	000			**		
	Registr	ar	LED % O CO	UI JAKARAGO JU	FOR KAN	346					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 24, Peila Richard F. 2007 12:42 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4106 Chardel Road. Unit 1G Baltimore Nottingham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 15, 1 9. Birthplace (State or Foreign 1**∏** M 2□ F Months Days Hours 220-38-9974 65 1941 Maruland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore. Maryland Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4106 Chardel Road, Unit 1G 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No. If Yes, Give Vietnam Year or Dates: Era 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Era 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank R. Peila Helen Lanieski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald F. Peila (son) 4106 Chardel Rd., Unit 1G, Nottingham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2/27/2007 Baltimore. Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final inces disease or condition resulting in death) year Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 2 Fetal death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy perform 2/1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite

traumatic event,

Department of Health ar Important: If item 27 Is any injury or other trauonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

/Medical

Examiner physician and s the burial-trans Physician/Medical signed by the a Completed by page 2 s certificate Be this After Certification: nours after death.

neral Director: Af

filled in by the fur

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending

within 24 hours a To the Funeral L the Hospital

1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 28c. Injury at Work?

4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Drive Sui

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 02 4356

guare

29d. Date signed (Month, Day, Year) 200 7

Pattimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1103 Frankl 31. Date filed (Month, Day, Year)

Registrar

Medical

FEB 2 8 2007



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, James Anthony Pusateri 2007 4b. City, Town, or Location of Death 4c. County of Death Fallston Harford 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Days 1**X**M 2□ F Months Hours Min 63 July 29. 1943 10c. City, Town or Location Harford Fallston 10f. Zip Code 10g. Citizen of What Country?

1 - State Registrar

Gerald Richard	Rai	ley 1- For State Registrar	Stat	te of Maryla		tment of ificate of		nd Mer	ntal Hy		Reg. No	20	07	0605
Physic Medical Exam		Gerald R	. Raile	У						Date of De	eath	<del>06-</del> 2007		3. Time of Death 0030 hrs
		4a. Facility Name (if Shady Grove		give street and nun	nber)		tb. City, Town, o	or Location			4	c. County of Montgom		
Funeral Director		5. Social Security No.		Sex 2 F	7. Age (In yrs. las 43	t birthday) Yrs.	If Under 1 Ye	_	44.	8. Date of B Sept		- 1	Foreign	place (State or htry <b>Tennesse</b>
any		Usual Residence of 10a. State	Decedent IOb. County	<u> </u>	10c. City, T	own or Locati	on		-				_	10d Inside City Limits
Maryland 28a-f show 1 at once.	Director	MD 10e. Street and Num	Montg	omery		Rock	Ville				10a Cit	izen of Wha		1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	al Dire	50 Metro	oplitan						878				SA	
72 hours after death with the Maryland n'matural", or items 23a or 28s-f shc al Exminer must be notified at once	by Funeral	11. Marital Status  1 X Never Married  3 Widowed	4 Divorc	ed Armed For 1 Yes  ed If Yes, Give Year or Dates:	2.X No	If Ye	S Decedent of Hes, specify Cuba	an, Mexicar	n, Puerto Ri		o-	14. Race - White,	etc.	an Indian, Black,
36 in 72 hours nan "natu	Completed	15. Decedent's Edu Elementary/Secon		College (1-		during mo	's Usual Occupa est of working life	e. DO NOT			16b.	Kind of Busir	ness/Ind	dustry
21215-0036 July be filed within 72 Marked Hygiene. marked other than 'e event, the M-dical		17. Father's Name (F	First, Middle, La	O (st)		truc	k drive		r's Name (F	irst, Middle,		anitat Surname)	ion	
2121 hould be find Mental Is is marked	To Be	Bernard 19a. Informant's Nam		-		19b. Mailing	Address (Stre					oughs	State, 2	Zip Code)
ME and 2 s alth as m 27		20a. Method of Dispo	osition	th/siste	20b. Pla	11589	Libert	y Oak	ks Dri		eder		MD	21701
Baltimore, permit Pages 1 ar Department of Hee Important: If ite		4 Donation 5	Y One Spec	Removal from	+ <u> </u>	matory or oth								
Baf permit Depar Impor		21. Signet ure of Fund	1/1/1	/ Ma		IBa1	meandAddes timore,	MD	21201					Street
Physician /Medical Examiner		23a. Part I. Enter the fatture. List only Immediate Cause (Fi	one cause on inal disease	tiplications that cau each line. a. Cocaine :			e mode of dying	, such as c	cardiac or re	espiratory an	rest, sho	ock, or heart		Approximate Interval Between Onset and Death
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0, e be executed sician and burial - transit		events resulting in de		Due to (or as a c										
'60, cate be ex physician he burial	Medical	X UNPENDED	Į,	X AMENDED 32 #2,236	a,27,28a-f	, perME,	g865, 3/	/2/07 1	T		230	d. Date of de	livery	
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Variant after death.  To the Funcau Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent propast 12 months?			nt at time of death		al death 3 er (Specify)	Ectopic	c pregnancy			Month	Day	y Year
, P.O. tres that the signed by t	by	Part II. Other signific	cant condition	s contributing to c	leath but not resu	lting in the ur	derlying cause	given in Pa	art I.	23e. Did to	_	_		cause of death?
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Vital Rec ysician: The l his certificate l	Be Co	25. Was case referred examiner?	d to medical	Hospital:				Othor	(Check only				Yes	2 No
of Vi ing Physi After this	n: To	1 Yes 2 27. Manner of Death	No	28a. Date of	Injury 28	Outpatient  Bb. Time of In	ury 28c. Inju	iry at Work		d. Describe	Resider how inju		Other:	
Division of Divisi	Certification:	2 Accident 3 Suicide	5 Pending Investiga 6 Could no determin	ot be 28e. Place of	1/2007 Fi of Injury - At home Found at	nd 11:45 e, farm, street junkyard	pm	Yes 2 X	c. 28	nk。 f. Location () .or,Town,.S	Street ar	nd Number of	r Rural ropo.	Route Number, City Litan Court
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce		ertifying Physi	ician: To the best of er:On the basis of	examination and/				ice, and du		se(s) and			ause(s)
Too	Me	29b. Signature and tit	tle of certifier	and manner stat	ed.		29c. Licens				1	Date signed ruary 5, 2		Day, Year)
		30. Name and addres Theodore M.		. –	of death (Item 23 t Medical Exa	•	11 Penn Sti	reet, Bal	Itimore, I	MD 21201	1			
St Regis	ate	31. Date filed (Month,	Day, Year)		strar's Signature	door	K)		·					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 17, 2007 7:21A. M **Physician** Reiss Gwendoline Graham /Medical 4a. Facility Name (If not institution, give street and number)
Heartland Healtcare of Hyattsville 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Hyattsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month Day year) Jan. 7, 1919 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F London, England 88 104-26-5235 Director Usual Residence of Decedent s filed within 72 hours after death with the Maryland if Hygiene.
other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Itsm 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar natat be notified at 14 Yes 2 No Washington D.C. Directo 10g. Citizen of What Country? 10f. Zip Code 10a Street and Number United States 20002 139 12th Street, N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ₺ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (Fjrst, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Menial Hy Important: If Itsm 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) (unk) Agnes Charles Heales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2817 Caramoor Lane San Ramon, CA 94582 John E. Reiss -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 2/24/2007 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V.Bor wardt Funeral Home, PA 4400 Powder Mill koad Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a considuence of) Examiner The law requires that the death certificate be executed ng physicien and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐No 4☐Pregnant at time of death 5 Other (specify) the be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pulmonary Nodules 1 Yes 2 No 3 Probably 4 HUnknown cete hes been sig page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 1 XYes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification; After or Attending 5 Pending investigation 1 Yes 2 No after death. 2 ☐ Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral E 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and clace, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2/26/07 DO058290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMRVIS AVENUE, RIVERDALE, MY 20137 SURESHKUMAN HTATTUM signature Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23 State of Mary 2864 Department Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Catherine Robbins Month 2007 Jean 8:45a February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) 75 Yrs. 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Nov 27 1931 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □XF Michigan 272-28-3488 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Carroll Eldersburg 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6465 Tydings Road 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary FBI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Hammer Mildred Rau ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6465 Tydings Road Eldersburg, MD 21784 Mr. John Robbins (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State  $\frac{2}{15}$  Cem. 15/2007 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Sam Houston Vet. San Antonio, TX 4 ☐Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) <u>Sykesville, MD 21784 (410)-795-1400</u> UM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death End Stage Dementia Immediate Cause (Final Physician disease or condition Due to (or as a consequence o) /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical signed by the attending I IF FEMALE: 23b. Was decedent oregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of reath? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has t 24a Was an within 24 hours after deam.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

inte 340

Owings mills, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SULLIVAN, MARTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Physical Management of Section 1997 Per PH C866 A / 10/06/4/1997 Per PH C8	Mervis Safford	1 F	- For State		ate of Maryla r				and Me	ntal Hyg		g. No. 200	7 06063	
St. Mary's hospital in the form of whether and current in the property of the		1/		(	-1/									
Second District   Second Dis	- Andrews			not institutio		nber)						4c. County of De	eath	
To distance the part of the pa			5. S4379ec74 <u>y N</u>	4741		7. Age (In yrs. I		Months		irs Min.		Foi	reign	
The state of the s	any					10c. City	, Town or Lo	cation					10d Inside City Limits	
The state of the s	and show :	ē			las	Combine								
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2   Summand Address of Facility   Stall Tings Funder   P.A.	after death al", or iten		3 Widowed	4 X Div	1 X Yes orced If Yes, Give Year or Dates:	2 No	1	Yes 2 X	No specif	fy:	·	Specify:	White	
2   Summand Address of Facility   Stall Tings Funder   P.A.	2 hours "natur											16b. Kind of Busine	ss/Industry	
2   Summand Address of Facility   Stall Tings Funder   P.A.	0036 vithin 7 ene. er than Medica							Electri					rical	
2   Summand Address of Facility   Stall Tings Funder   P.A.	:15-0 e filed v al Hygi red othe											faiden Surname)		
2   Summand Address of Facility   Stall Tings Funder   P.A.	212 nould be id Ment is mark			me/Relations	hip (Type, Print )	′ \		,	Street and N	umber or Rura	al Route Num			
2   Summand Address of Facility   Stall Tings Funder   P.A.	, ME and 2 sl ealth ar tem 27	-				20b.	Place of Dis	position (Name		orive, Trabo	Combin Combin	10, IEXAS 20c. Location - City	/5159 or Town, State	
23 Amme and Address of Facility   Stall Tings Funcher   Forest and Address of Facility   Stall Tings Funcher   Forest and Address of Facility   Stall Tings Funcher   Forest and Between Onset	nore		***			iii State	-		·y			Franklin	Co., Texas	
Physician Modical Samminer  238. Part I. Ente-the disease or complications into Javased the death. Do not enter the mode of dying, such as cardiac or respiratory erreal, shock or fleet feature. Each feature is a consequence of joint or condition resulting in death)  259. Part I. Ente-the disease or complications into Javased the death. Do not enter the mode of dying, such as cardiac or respiratory erreal, shock or fleet feature. Each feature is a consequence of joint or condition resulting in death)  250. Part I. Ente-the disease or complications in the Javased the death of the condition of the	Saltir ermit F epartme nporta	Ì				11		2. Name and Ad	dress of Faci	lity St	alling	s Funeral	Home, P.A.	
Modical Examiner  The second of the second o		1	23a. Part I. Enterth	e disease, or	complications that ca	used the death	n. Do not ent	3	ying, such as	II KOdO	spiratory arre	adena, MD est, shock, or heart	Approximate Interval	
The containor resulting in death)  Sequentially list conditions  Due to (or as a consequence of):	/Medical		failure. List or	one cause	on each live.									
The first placed of the plant o	ZAGIIIIICI				Due to (or as a	consequence o	of):							
Part II. Other significant conditions  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  248  Was an autopsy  1		niner	if any, leading to im	mediate rlying Cause	C							<u>.</u>		
Part II. Other significant conditions  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  Chronic alcohol abuse  Part II. Other significant conditions  Chronic alcohol abuse  248  Was an autopsy  1	ا الله الله الله الله الله الله الله ال	Exa				consequence (	isequence or).							
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25. Was case referred to medical examiner?  1 Vers 2 No  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  27. Manner of Death  28c. Injury at Work?  28d. Describe how injury occurred  28d. D	O. B.	Ę.	Part II. Other signi	ficant condit			resulting in t	he underlying ca	use given in	Part I.	23e. Did to	bacco use contribute	e to the cause of death?	
25. Was case referred to medical examiner?  1 Vers 2 No  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  27. Manner of Death  28c. Injury at Work?  28d. Describe how injury occurred  28d. D	S, P.		Chronic ald	cohol abus	se						Charles Co.	-		
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and dates of person who completed cause of death (them 23a) 2 C. License number O.C.M.E. February 22, 2007	Rec n: The tiffcate or, page		25 Was case refer	red to medica	al			26.	Place of Dea	th (Check onl		2 No 1 🗸	Yes 2 No	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the cause (s) 2 Med	Vita nysician this cer	o B	examiner?		Hospital: 1		ER/Outpat		` .				ther:	
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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the cause (s) 2 Med	r Atten r Atten er deatl rector:	ficati		Inve	stigation 28e Place	e of Injury - At I	home, farm,	street, factory, o					r Rural Route Number, City	
29b. Signature and title of certifier  O.C.M.E.  February 22, 2007  30. Name and address of person who completed cause of death (them 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Div Dival or ours aft	Certi	4 Homicide	dete	ermined (Specify)									
29b. Signature and title of certifier  O.C.M.E.  February 22, 2007  30. Name and address of person who completed cause of death (them 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the Hos tin 24 h the Fun		(Check only		aminer: On the basis	of examination	dge, death o and/or inves	ccurred at the tire tigation, in my o	ne, date and pinion, death	place, and du occurred at th	ie to the caus he time, date	e(s) and manner as and place, and due to	stated o the cause(s)	
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Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Col	-1	UTE	10		(	D.C.M.E.			February 22, 2	2007	
	5							Penn Street,	Baltimore	, MD 2120	01			
		ate	31. Date filed (Mon	th, Day Year	2007 32 Re	egistrar's Signa	ure do	ale						

Physician / Modela Reality Name (if not institution, give streat and number)  Clarence A. Stivers  Clarence A. Stivers  Ad. City, Town, or Location of Death  4a. City, Town, or Location of Death  Clarksville  Clarksville  Clarksville  Clarksville  Clarksville  Under Very If Under V				1 - For State Registrar		aryland / De	partmer ertificat			and M	lental H	lygien Reg. N	6	007	0606
Claretice A   Stivers   Feb. 23, 2007   139   139   139   139   130		Physic	ian	Decedent's Name (First, Middle, Last											3. Time of Death
Final Directors   Control of Co															1:39 P M
2. Scotts actively names   5 Section   5		Exami	ner		street and number)							4	c. Coun	ty of Death	
Double   The Control   Total Interfere of Decement   Total Interfere   Total Interference														rd	
Double   The Control   Total Interfere of Decement   Total Interfere   Total Interference				· · · · · · · · · · · · · · · · · · ·			Months				8. Date of I	Birth Day, Yea	810	Cou	ntry)
Sociate   Soci						07		l			NOV.	23,1	919	Mary	Land
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Burnelsay/Seconday (0-12)   College (1-4or 4-a)   Dispatcher   Ufility		Many Feb	ţ	Maryland Howard		Clarks	ville								1 ☐ Yes 2 🔼 No
Burnelsay/Seconday (0-12)   College (1-4or 4-a)   Dispatcher   Ufility		r 28e	rec				10f. Zip	Code				10g. C	itizen of	What Cour	ntry?
Burnelsay/Seconday (0-12)   College (1-4or 4-a)   Dispatcher   Ufility		h with	0	6430 Galway Drive			210	129				Unit	t o d	Stata	
Burnelsay/Seconday (0-12)   College (1-4or 4-a)   Dispatcher   Ufility		deat	ner		12. Was Decedent	Ever in U.S. 1	3. Was Dece	dent of H	ispanic Orig	gin? (Spe	cify Yes or		14. Ra	ce - Americ	can Indian,
Burnelsay/Seconday (0-12)   College (1-4or 4-a)   Dispatcher   Ufility	ဖွ	after or Ite		1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □					, Puerto	Hican, etc.)				etc.
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Service 2 Constraints and Share 2 Constraints and Shar	5	72 h	ete	15. Decedent's Edu (Specify only highest grad	cation completed)	(G	ive kind of wo	rk done	during most	of works	ng	16b.	Kind of I	Business/In	dustry
Service 2 Constraints and Share 2 Constraints and Shar	121	vithin De.n.	mpi		College (1-4or	5+)	e. DO NOT u	se retired	1)		,				
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Service 2 Constraints and Share 2 Constraints and Shar	e,	1 and Health			o / Daugh		O Galw	ray D	r., C						Chat.
Physician // Medical Examiner  23. Part-Note: The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate inmodates Cause (Final Immodates Cause (Final	کر	m O		1 X Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, c	rematory or c	ther plac		ebru	ary 27	7			
Physician // Medical Examiner  23. Part-Note: The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate inmodates Cause (Final Immodates Cause (Final	Ë	rt Part			-		_								, Maryland
Physician inference of the course of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Inference Standard Cause (Final Inferen	Ba	Depermine Company Indiana		Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, M											21061
Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):    Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):   Cause (Disease or influy from the past 12 months? 1   Due to (or as a consequence of):				Immediate Cause (Final disease or condition	e cause on each I	d the death. Do not one.	enter the mod	se of dyin	g, such as o	cardiac o	r respiratory	arrest,			
25. Was case referred to medical examiner?  1	8760,	Examiner	Examin	triat initiated events	Due to (or as	consequence of):	le si	hee	art	fa	rdu	l			
25. Was case referred to medical examiner?  1	O. Box 6	the death certific by the attending p ached for use as i	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq 12 \) No	1□Live birth 4□Pregnant at	2 Fetal death									•
25. Was case referred to medical examiner?  1		s that ned b		Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying c	ause give	en in Part I.		23e. Dio	tobacco	use con	tribute to th	ne cause of death?
25. Was case referred to medical examiner?  1	ğ	auire n sig uld b		undang	- tre	ut in	cele	7			10	Yes 2	No	3 Prob	ably 4 □Unknown
25. Was case referred to medical examiner?  1	000	s bee	jet	0		V					24a. Wa	s an	24h	Were autor	nsy findings available
25. Was case referred to medical examiner?  1	æ	he te	E			····					aut	opsy		prior to con	
1 Accident   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Belace of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   February 26, 2007   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029   31. Date filed (Month, Day, Year)   32. Registrar's Signature	<u>a</u>		0	25. Was case referred to medical					OC Place	of Dooth			)	1 ∐ Yes	2 □ No
1 Accident   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   6   Could not be determined   2   Belace of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   February 26, 2007   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029   31. Date filed (Month, Day, Year)   32. Registrar's Signature	>	ysicia s cer direct	0	examiner?	ospital:	ent 2 \(\sum_{\text{EB/Outpat}}\)	ent 3 DC	Othe					e 🗆 🗆	(64	.1
State   Stat	0	g Ph er thi		27. Manner of Death									//		
29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ö	ath. r: Att	atio		(Month, Da)	y rear) Injun				lo					
29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	-	ef or Atte s after des al Director ed in by th	Sertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office							8f. Location City or To	(Street a	nd Numi e)	oer or Rurai	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ne Hospil ne Funera		Check only 2 Medical Examir	er: On the basis of	examination and/or	ath occurred investigation,	at the tim	e, date and pinion, death	place, a	nd due to the	e cause(s , date an	) and m d place,	anner as sta and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the Cong	Σ	29b. Signature and title of certifie	.111	)				/ >		29d. Da	ıte signe	d (Month, L	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Abdo, M.D., 5005 Signal Bell Ct., Clarksville, Maryland 21029  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	•			> Solle	-100			15	0870			Feb:	ruar	y 26.	2007
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		6					e, Print)				Jary 1 o			, _0,	
				31. Date filed (Month, Day, Year)	32. Registra		1			-, 1	y ±a.		. 029		

			1 – For Registrar	State of Maryla			nt of He te of D		Mental H	ygien	<u> </u>	7	060	165
	Physici	_	1. Decedent's Name (First, Middle, Las CMAR LOTTS						2. Date of Month	Da		Year 107	3. Time	of Death
	/Medio Examin		4a. Facility Name (If not institution, give			4b. Cit		ocation of Deat			c. County o			10
	Funeral Director		5. Social Security Number 6. S 216-34-4779	ex	s. last birthday) Yrs.	If Und Months	er 1 Year	If Under 24 Hrs Hours Min.	(Month,	Birth Day, Year 04	35	9. Birthp Coun	lace (State try)	or Foreign D
	aryland ehow	2	Usual Residence of Decedent  10a. State 10b. County	1	City, Town or Lo							1	0d. Inside	City Limits
	or 28a-1	Director	MD NA  10e. Street and Number		Baltim		ip Code			10g. C	itizen of Wh			
36	rs after death w	by Funeral	3212 Greenmead  11. Marital Status  X Never Married 2 Married 3 Widowed 4 Divorced	Ave  12. Was Decedent Ever in Armed Forces?  1			edent of Hist ecify Cuban,	244  panic Origin? (S Mexican, Puer  Specify:	Specify Yes or to Rican, etc.)	No-	U . S  14. Race Black, Specify:	Americ White,		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, It is Mulical Examere I must be mailted at	Completed b	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation	(Give	kind of w DO NOT	ual Occupati rork done du use retired)	ring most of wo	rking		Kind of Bus	iness/Ind	dustry	y Adm
yland ?	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Charles M. Smi	th Sr.			Г	8. Mother's Na Orothy	Boar	dley	7			
	カミトラ	18.	19a. Informant's Name/Relationship (1) Sharon Robinso 20a. Method of Disposition	n-Daughter		Gr	eenme	ad Ave		timo	ore,	Md	212	44
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 eny injury or other once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	rbutus	matory or Me	other place) moria	1 2/2			ocation - C			
Ba	Department of the control of the con		> Amould C:	aught	43	300		sh Ave			ce, M	ld	2121	
8760,	hysician be executed /Medical Examiner transit the burial-transit	dical Examiner	23a. Parf. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	iduence of):  Q Divinguence of):	1	der						Interval Be	
O. Box 6	ath certi	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preging 1 Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	]Ectopic ] Other (:	pregnancy specify)				23d. Date Monti		ry Day	Year
rds, P.	quires that the de n signed by the a uld be detached f	by	Part II. Dther significant conditions of	ontributing to death but not re	sulting in the u	nderlying	cause given	in Part I.		d tobacco	use contrib	ute to th		death?
Il Records,	The law require cate has been si page 2 should I	Completed							24a. Wi au pe 1 🗆 Yes	topsy rformed?	de.	or to con ath?	osy finding apletion of 22 No	s available cause of
<b>X</b>	Physician: The this certificate al director, pag	o Be	25. Was case referred to medical examiner?	Hospitai:	/		Other	26. Place of Dea						
Division of Vital	Alter funer	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury a Work?	4   Ivuising r	lome 5 ☐ Re 28d. Describ				)	
Divis	tal or Attendest is after death al Director; ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, facto	ry, office		28f. Location City or 7	(Street a		or Rura	Route Nu	mber,
	To the Hospital within 24 hours a for the Funeral I completely filled	Medical	(Check only 2   Medical Examone)	ysician: To the best of my kr liner: On the basis of examin and manner stated.	nation and/or in	vestigatio	n, in my opir	tion, death occu	irred at the tim	e, date an	id place, an	d due to	the cause	
)	To To Com	Σ	29b. Signature and title of certifier	)		2	9c. License r 9577	Z T		29d. Da	ate signed (	Month, L	Day, Year)	
6	) Y		30. Name and orderss of person who	32. Segistrar's Sign	em 23a) (Type,	Print)	Nam	en B	Wol-	Bo	ustr.	nol	2 21	239
	Sta Registr	37.00	31. Date filed (Month, Day, Year) FEB 2 8 2	32. Segistrar's Sign	natura,	nach	مر							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Sava FEBRUARY 2007 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYNEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗷 F Director 120-26-0930 Usual Residence of Decedent 08/15/1921 filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 319 Pine St 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3. Widowed 4 ☐ Divorced Black 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Bright Rosa Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosaron Smith/Daughter 319 Pine St. Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 Cremation 3 ☐ Removal from State Feb 28 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Retha Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** urosclerotic Cardiovascular /Medical Due to (or as a consequence of): Examiner Biz Hamen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transit pothyrou ism Due to (of the a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? (es 2 No page 1□ Yes Division or Vital 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury within 24 hours after useru...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital ertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar 940 Eastern Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Sad

31. Date filed (Month, Day, Year)

			State of Maryland / Dep		•	_
				rtificate of Death	Reg. I	
	Physicia		Decedent's Name (First, Middle, Last)     Sarah B. Savage			Oay Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		23, 2007 1:45 a <sup>M</sup> 4c. County of Death
		1	Crescent Cities Nursing Home	Riverdale		Prince Georges
文	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9 Birtholace (State or Foreign
	Director		Usual Residence of Decedent		Dec. 9, 1	920 Accomac, Va.
	yland yow		10a. State 10b. County 10c. City, Town or L	ocation	<u> </u>	10d. Inside City Limits
	e Mar	Director	Maryland Prince Georges Camp Sp	rings		1 5 Yes 2 □ No
	or 26	Dire	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	sath v	erai	4404 Reamy Rd.  11 Marital Status  12. Was Decedent Ever in U.S.  13.	20746		United States  14. Race - American Indian.
10	r Item	Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
030	72 hours after death with the Maryland natural; or Herns 23s or 28a-f show Jisal Examination to the confilled at		3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💆 No Specify:		Specify: Black
5-0	72 h	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of workir DO NOT use retired)	16b.	Kind of Business/Industry
121	within ene. than "i	mpi	Elementary/Secondary (0-12) College (1-4or 5+)			Medical
9	e filed within al Hygiene. I other than ' vent, Ine we		17. Father's Name (First, Middle, Last)	sing Assistant  18. Mother's Name	(First, Middle, Maid	
lan	Aental rked o	To Be	William Bagwell	Jennie (	C. Simpkin	ns
Maryland 21215-0036	2 should be and Mental Is marked (			ng Address (Street and Number or Rura		
	l and feaith im 27 her ti		Preston Savage / Son 1 Wa  20a. Method of Disposition 20b. Place of Disp	tson Street Onanco		23417 Location - City or Town, State
nor	not of it. If its		1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)  1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)	matory or other place)	1	comac, Va.
Baltimore,	permit. Pages: Department of It Important: If ite any injury or ot		- Ebonation of Control (opposity)	3/3/20	307	
ä	Depa Impo any is		+ Kither Surge 101085	2. Name and Address of Facility Alexander S. Pope, 5538 Mariboro Pike	/Forestvi	.11e, Md. 20747
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical			ote Candiova	scular 1	Discuse years
	Examiner		Due to (or as a consequence of):			
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
4	ecuted and transi	Examiner	that initiated events c.			
2,097	ate be executed hysician and the burial-transit	cal E	Due to (or as a consequence of):			
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Вох	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
		sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.0	hat the		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	indertying cause given in Part I	23e Did tohacc	o use contribute to the cause of death?
Records,	es pe pe	Completed by	Demantia	masnying education great in Francis.	1 🗆 Yes	
COL	> 40 0	iete	Hypertensión		24a. Was an	24b. Were autopsy findings available
Re	о <u>г</u> е	шо			autopsy performed 1 ☐ Yes 2 ☐ 1	
Vital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of \	S S 5	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	The second secon		
no	ding h. After fune	tion	27. Manner of Death  1 ☑ Atural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	ljury occurred
Division	or Attending after death, Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si		Bf. Location (Street	and Number or Rural Route Number,
4	tal or s afte al Dire	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town, Sta	are)
/	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause and at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the h within 24 To the R complete	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	_		Dunllinllem	201852	2	3 LEBUAM 2007
	'}		30 Name and address of person who completed cause of death (Item 23a) (Type PSV A. DEVSEMO 4203 (	Quelachone (	Rel Hya	HSU: 11eMi) 2078
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		. , ,	3/1
10	Registr	1000	FEB 2 7 2007 American Af A	edle		

			For State of Maryland / Department of Health and No. 1 - State Registrar Certificate of Death	Mental Hygie	2007 00000
	Dhysiai		1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year
2	Physicia /Medic		ROSE L. TONEY	FEDRIVAR	127,2007 105 am
ל	Examin	er	4a. Facility Name (If not institution, give street and number)  Maryland General Hospital Baltimore	rty	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
-05%			248-01-5141 94 Yrs.  Usual Residence of Decedent	MAY 6, 19	912 SC
	yland how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
:	Be-f.	Director	MD BALTIMORE		1 <b>X</b> Yes 2 □ No
	or 24	Dire	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Country?
	ath w	rai	1100 PENNSYLVANIA AVE. APT. 1011 21201		USA 14. Race - American Indian,
	Item de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Tyes 2 Ano	Rican, etc.)	Black, White, etc.
5-0036	within 72 hours atter death with the Maryland ene. Hen "haturel", or teme 23a or 28e-f ehow the Modical Examiner must be notified at	by	3 📆 Widowed 4 □ Divorced		Specify: BLACK
Ö I	"naturel",	ted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work		b. Kind of Business/Industry
2	ithin 199.	Completed	Flementary/Secondary (0.12) College (1-4or 5+)	Na ing	HOMEC
2	be filed within ital Hygiene. Id other then event, the My		) DOMESTIC	- (Final Asidal) - 14-1	HOMES
	should be filed with nd Mental Hygiene marked other the imatic event, the	o Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  GEORGE HALL  DELLA	ne (First, Middle, Mai REVEL	den Sumame)
2	s 1 end 2 should f Health and Men frem 27 ie marke other treumatic	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru.		ity or Town, State, Zip Code)
	27 ic		MARJORIE HALL/DAUGHTER 4700 GARRISON BLVD.	BALTIMORE	, MD 21215
Φ.	es 1 end of Health of Hem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20d	c. Location - City or Town, State
Ë	Pages nent of int: if it iry or o		1 Surial 2 Ucremation 3 UHemoval from State	5-07	SYKESVILLE, MD
Balt	permit. Page Depertment: important: fi eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JA		RTON & SON F.H., INC.
			23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shoot, or heart failure. List only one cause on each line.		
, F	Physician		Immediate Cause (Final disease or condition		Onset and Death
	/Medical Examiner		resulting in death)		
	Laaninei	_	Supertially list conditions. If any leading to immediate  Due to (or as a consequence of):		
	led Isit	niner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)  C. C	+	
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99	tificat ng phy as th	ledi			
Вох	leath certific ettending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy		23d. Date of delivery
	The law requires that the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?  1		Month Day Year
P.0	that the de led by the e detached i	F.	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobac	co use contribute to the cause of death?
ds,	signed be det	d by	and the second s	1 ☐ Yes	. /
Division of Vital Records,	v requir been s	ete		24a. Was an	24h Ware autocu findings available
He He	helav shas ge2	Completed		autopsy performed	
ā		ပိ	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes 2 ☑ th (Check only one)	No 1 Yes 2 No
>	ysician: The is certificate hi director, page	To B	examiner?		e 6 ☐Other (Specify)
ō	Attending Physician: r death. ector: After this certifice by the funeral director.		27. Manymer of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of 28c. Injury at Injury Work?	28d. Describe how	
<u> </u>	endir eath. or: Al	atic	2 Accident investigation M 1 Yes 2 No		
Ž	or Att after d Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, state)
	pitei ours a eref [		200 Codifice 15 Codificing Physicians To the heat of my knowledge death account at the time date and class	and due to the cour	-/-\
15	To the Hospitel or Attending Physicial Annual Physicial Annual Physicial Phy	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date	and place, and due to the cause(s)
	To the Mithin Young	Me	29b. Signature and title of coefficier 29c. License number	29d.	Date signed (Month, Day, Year)
			M. Mirace 100 84514	1	1/27/07
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10 10	10/10
	0		Maryam Merater, M.D. 90 Tharyle	una Gu	eneral Hospital
	Sta Registr		31. Date filed Month, Day, Year)  32. Registrar's Signature		
	negisti	aı	FEB 2 8 2007		

			_ For	State of Marylar	nd / Dep	artment of I	Health and	Mental Hy	giene	gibic.	0 0 0 0
		_	1 State						Reg. No. 2	007	0606
ч	Physici	an	1. Decedent's Name (First, Middle, Las	st)	10	1151		2. Date of De Month	ath Day	Year	3. Time of Death
Want	/Medic		BHENDIT	ryl	100	141		Februa	- 1	2007	10:39P.M.
	Examir	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deal	1 1	4c. Cou	nty of Death	- 0 <del>-</del>
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	. last birthday)	If Under 1 Year			th .	9. Birth	place (State or Foreign
	Director		220-36-3328	□M 2K□F 65	5 Yrs.	Months Days	Hours Min.	. (Month, Da		Coui	MD
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 0	ity. Town or Le	nation					104 1-14-02-11-24
	laryla shov	J.			,						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N 28a-f	Director	MD Balti  10e. Street and Number	more	Pike	sville 10f. Zip Code			10g. Citizen	of What Cou	
	3a or	Ö	4705 Marling R	5.c.c			21208		-	.S.A.	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.		Hispanic Origin? (S ban, Mexican, Puel	Specify Yes or No		Race - Americ	can Indian,
9	after or Ite	/Fu	1 ☐ Never Married 2 ☐ Married	Yes 2 No		1 ☐ Yes 2X No		no nican, etc.)		Black, White, ecify: E	etc. Black
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	100 000						
15-	n 72 i "nat edica	lete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of wo ed)	orking	16b. Kind o	f Business/In	dustry
212	filed withi Hygiene. ther than int, the M	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		chine Op				Noxel	.1
פָּ	be filed tal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last,	1				me (First, Middle,	Maiden Surr	name)	
/lar	should be and Mental is marked o aumatic eve	70 E	Clarence Ward				Cather	ine Lig	gins		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if the 23 or 28a-f show item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Stree	t and Number or R	Rural Route Numb	er, City or To	vn, State, Zip	Code)
	1 and 2 Health em 27 i		Leo Taylor Sr. 20a. Method of Disposition	-Husband		Marlin Disition (Name of	ng Road	, Pikes			21208
Baltimore,	0 0		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other pla	t			on - City or To	
Ħ	구함라는		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer			emorial 2. Name and Addr	Park 3,	/2/07	Randa	llstc	wn, Md
Ba	Depar Impor any Ir		Ahma A	- Abam asa	. ,   1	larch F	/H West	- D-14		N 3	21215
			23a. Part1. Enter the disease, or com	plications that caused the dea	th. Do not en	ter the mode of dy	bash Avering, such as cardia	e BAIC ac or respiratory a	<u>imore</u> rrest,	Ma	21215 Approximate
	Physician		shock, or heart fallure. List only Immediate Cause (Final disease or condition	one cause on each line.	200 ]	12 ant-J	T. 1.0	,			Interval Between Onset and Death
1	/Medical		resulting in death)	a. Due to (or as a conse	quence of):	Very /	) -				
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760,	ate be executed hysician and the burial-transit	calE	l l	1) Ma	e Azo	na	11 true				
687	ficate physis the			d	7	1,4					
Box	n certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr		76			23d.	Date of deliv	ery
Ш	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		⊒Ectopic pregnand ⊒ Other (s <i>pecify)</i> _	cy			Month	Day Year
P.0	at the I by the stache	Phys	9 Unknown								
s,	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by	Part II. Other significant conditions of	contributing to death but not re-	sulting in the u	inderlying cause gi	iven in Part I.				he cause of death?
Ö	w requir been si should I	Completed						10		3 Prol	bably 4 Conkriown
<b>3ec</b>	has the law	mple		***************************************				24a. Was	osv	b. Were auto prior to co death?	opsy findings available impletion of cause of
a	n: Th ficate nr, pag		25. Was case referred to medical						rment? 2 No	1 ☐ Yes	2 No
or Vital Records,	Physician: r this certifica ral director, p	o Be	examiner?	Hospital: 1 Inpatient 2	BR/Outpatie	nt 3□ DOA Ot	thor:	eath <i>(Check only o</i> Home 5 ☐ Resi		Other (Core	
0	g Phy er this eral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe			ry)
Division	Attending ir death. ector: After by the fune	Certification:	1 Natural 5 Pending	1	Injury		ork? ∃Yes 2⊟No				
ivis	ir Atte	tific	3 Suicide 6 Could not by 4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, st	reet, factory, office	)	28f. Location (a City or Tox	Street and Nu	mber or Rur	al Route Number,
Ω	oital c urs af eral D		4								
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exal	nysician: To the best of my kn niner: On the basis of examin and manner stated.	iowledge, dea ation and/or i	th occurred at the nivestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	date and pla	manner as s ce, and due t	stated. o the cause(s)
	o the	Mec	29b. Signature and title of certifier	and mariner stateg.		29c. Licen	ise number		29d. Date sig	ned (Month,	Day, Year)
			Asatua.	$\sim$	D	D4	3977		Elm	G	TONE HE
,	1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)			05/11	7.	1 2001
4	(		mokn exermix	1.31 Hosts	1 100	line, Gl	en Am	me - 1	~~ (m	21061	1
	Sta	ite	31. Date filed (Month, Day, Year)	32. Projetiar's Sign	nature	A. A.					

State Registrar

FEB 2 8 2007

State Registrar

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anton Van Velsen State of Maryland / Department of Health and Mental Hygiene 2007 0607 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 20, 2007 Medical Examiner 2300 hrs Anton Van Velsen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3018 California Avenue **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 8irthplace (State or **Funeral** Months Days Hours Director 215-68-5448 1 X M 2 58 Feb 26, Country) Holland 1948 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location s 23a or 28a-f show : e notified at once. 1 Yes 2 No Baltimore Parkville Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygone.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Modical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3018 California Avenue 21234 USA/Holland Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: white ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 chef restaraunts 17, Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) Be Gerard-Johan Van Velsen Jantina Maria Alverigh 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Wright/friend 3018 California Avenue Parkville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: injury or oth 4 X Donation 5 Other Specify 21. Si naturi of Rolla 111 e Licensee 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street pertor 21201 Baltimore, MD ert I. Enter the disease, or complications to hure. List only one cause on each line. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Madieni Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical g physician a X UNPENDED AMENDED, PII, 27, perME, g865, 3/7/07 TT Division of Vital Records, P.O. Box 68760, 23d Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcohol abuse: remote lung cancer Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has b death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1X Natural 1 Yes 2 No thin 24 hours after death Director: d in by the f 5 Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie February 21, 2007 O.C.M.E. Jew 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

Registrar DHMH 17 Rev 1/2001

OCMF 2006

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

			State of Mar	ryland				lental Hy	giene2 ()	07	06072
	1 - Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Date of Death  2. Date of Death									3. Time of Death	
	Physici	Physician							Day	Year	7: 089m
	/Medic Examin	Betty Jean  4a. Facility Name (If not institution, give street and number)	4b. City. Town, or	r Location of Death	_ Oa -	4c. Count	v of Death	1.00			
	Exami	iei	Franklin Square Hospital	Con	for	7	dale		D	1tim	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			place (State or Foreign intry)
	Director			6	Yrs.	Months Days	Hours Will.		9, 1920	I11	inois
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Loc	ation					10d. Inside City Limits
	daryk f eho	ō	MD Baltimore	•	D -	rkville					1 ☐ Yes 21 No
	179 the	Director	10e. Street and Number		ra	10f. Zip Code			10g. Citizen of	What Cou	intry?
	deeth with the Marylend oms 23s or 28e-1 ehow if must be notified at	<u>=</u>	8800 Walther Blvd.			2	1234		U.S	. A .	
	deeti	by Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S	. 13. V	/as Decedent of H	lispanic Origin? (Spanic Mexican, Puerto	ecify Yes or No	- 14. Ra	ce - Ameri	can Indian,
9	or Ite	Fu	1 Never Married 2 Married 1 Yes 2 No	,		☐ Yes 21 No	Specify:	ritari, etc.)	Speci	ack, White,	, etc.
21215-0036	72 hours after naturel', or ite ileal Examina	d b	3 ★ Widowed 4 Divorced Year or Dates:							Wr	nite
<u>7</u>	n 72	lete	15. Decedent's Education (Specify only highest grade completed)		(Give i	ent's Usual Occup and of work done of ONOT use retired	during most of worki	ing	16b. Kind of E	iusiness/In	ndustry
212	within iene. than "	Completed	Elementary/Secondary (0·12) College (1-4or 5+)	)			an Servic	es	NJ Sta	te Po	olice
	e filed Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name				
Ta La	uld by Menta Menta Irked Irked	ToB	William Glen Sowers				Essie	Virgin	ia Mose		
S F	2 sho and I I mu		19a. Informant's Name/Relationship (Type, Print)				and Number or Rura		-		p Code)
ick, Beth	s 1 and 2 should be filed within 72 hours after deeth with the Marylen if Health and Mental Hygiene. Item 27 is marked other than "nature!", or items 23s or 28e-f show other traumatic event, the Modical Examinar must be trutified at		Stephen L. Vick Son	20h Bir			ove Road	Reiste			21136
/ick more,	in to the interest of the inte		20a. Method of Disposition 1 ☐ Burial 2 ဩ Cremation 3 ☐ Removal from State			sition (Name of atory or other place	1		20c. Location	- City or 10	own, State
<u>&gt;</u> ₽	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 le marked other than any injury or other traumatic event, tha Ms 00ce.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Carr		remation Name and Addres		8/07	Hampst		
Baltij	Depared Impo		Sterker M Jen	Ki			ral Home		isterst		21136
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death.						1110	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	nsis							Ponset and Death
	/Medical		resulting in death)  Due to (or as a	conseque	ence of):						a weens
	Examiner	L	ACQUELINATE TO TOTAL CONTROL AND THE PROPERTY OF THE PROPERTY			eumor	ria				
4	ed tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	conseque	ence of):						
h.	xecut and	хап	that initiated events c.  resulting in death) Last Due to (or as a continuous process)	conseque	ence of):					_	
38760,6	cate be executed physicien and the burial-transit	dical	d								
9	ifficati g phy as the	edic									
Вох	death certific ettending p	N/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2	pregnan		Ectopic pregnancy	,			ate of deliv	
Э.	ne deal the ett hed fo	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tir			Other (specify)			M	onth	Day Year
P. O.	es that the death cen igned by the ettendin be detached for use	by Physician/Me	9 ☐ Unknown  Part II. Other significant conditions contributing to death but	not recul	tion in the us	dorbina navan av	en in Dort I	220 Did	obacco una con	stribute to I	the cause of death?
ds,	ires tha signed d be det	d by	Chalecustitis atom	0 -		1/ation		10	~1		bably 4 Unknown
, or	* requir been s should	ete	Chorce go Title	201	1101	1191101		24a. Was			
Be .	The law requires that the death certifield has been signed by the ettending page 2 should be detached for use as	Completed						auto		prior to co death?	opsy findings avaitable ompletion of cause of
豆	ticien: Th certificete rector, pag		25. Was case referred to medical				26. Place of Death	1 Yes	2 12 No	1 🗆 Yes	2 No
<u> </u>	ysicie is cer direct	To Be	examiner? 1 ☐ Yes 2 🔼 No Hospital: 1 💢 Inpatient	2 DE	R/Outpatient	3□ DOA Oth				her (Speci	(v)
0	Attending Physicien: r death. ector: After this certifics by the funeral director, I	L:uC	27. Manner of Death  DENaturat 5 □ Pending  28a. Date of Injury (Month, Day)	1 2	28b. Time of Injury	28c. Injun Worl			how injury occu		,,
sio	ttendir death. ctor: Ay y the fu	catle	2 Accident investigation			M 1 🗆	Yes 2 □No				
Division of Vital Records, P.O.	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At horr (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rura	al Route Number,
u	spital ours a serel i		29a. Certifier 12 Certifying Physician: To the best of	my know	iedge, death	occurred at the tin	ne, date and place	and due to the	cause(s) and m	anner as (	stated
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete hes completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examiner: On the basis of e	examination	on and/or inv	estigation, in my o	pinion, death occurr	ed at the time,	date and place,	and due to	o the cause(s)
	To th withir To th comp	×	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month,	Dey, Year)
			1 harbor			C	25510	7	02-0	33-0	07
	5		30. Name and address of person who completed cause of dea	ath (Item 2	23a) (Type, f	Print)	7.	2.1	4	11.1	21227
	Sta	ate.	31. Date filed (Month, Day, Year) 32. Registrar	's Signati	trant	111 08 MG	are Duve	poal	HMORE,	Ma	L120/
	Registi		FEB 2 8 2007 Acres	S.	ATOM!						Dey, Year) 07 21237

		-	State Registrar	te of Maryland / Dep <i>Ce</i>	ertificate of De	anth	giene 007 06073
	Physici		1. Decedent's Name (First, Middle, Last)	ard		2. Date of De. Month	ath Day Year 1:52 AM
	/Medic Examin		4a. Facility Name (If not institution, give street a Spa ( rech Center		4b. City, Town, or Lo Annapol	is, Maryland	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 10 M 2	☐ F 7. Age (In yrs. last birthday Yrs.		Hours Min. 8. Date of Bin (Month, Da Sept 17	y, Year) 9. Birthplace (State or Foreign Country) 1111inois
	show	o.	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or I	Location		10d. Inside City Limits 1 ☐ Yes 2∑ No
	vith the N or 28e-f	Director	MD Anne Arun  10e. Street and Number	del Aima	10f. Zip Code	403	10g. Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is merked other then "natural", or Items 23e or 28e-f show or other traumetic event, the Medical Examiner must be neitlified at	by Funerai	1 Never Married 2 Married 1	is Decedent Ever in U.S. ned Forces?  Tyes 2 \( \text{No} \) No res, Give ar or Dates:	. Was Decedent of Hispa If Yes, specify Cuban, i	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	
Maryland 21215-0036	filed within 72 hou Hygiene. other then "natura ant, Ire Medical E	Completed	15. Decedent's Education (Specify only highest grade complete (0-12)  Elementary/Secondary (0-12)  1 2	Dieted) 16a. Dec (Giv life.	edent's Usual Occupations with the sedent's Usual Occupation of work done during DO NOT use retired)	on ing most of working	16b. Kind of Business/Industry  dairy
land 2	ld be filed within ental Hygiene. kad other then ic evant, Ibe M	To Be Co	17. Father's Name (First, Middle, Last)  James Joseph Ward			3. Mother's Name (First, Middle, Lilian Franc	Maiden Sumame) ces Dickenson
	1 and 2 should be Health and Mental tam 27 is markad o othar traumetic eve		19a. Informant's Name/Relationship (Type, Pr Katherine Ward/spou		iling Address (Street and B Sanstone (	d Number or Rural Route Numb Court Annapolis	er, City or Town, State, Zip Code) S , MD 21403
Baltimore,	Pages 1 a lent of Heis nt: If itam ry or otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov. 4 ፟፟ Donation 5 ☐ Other (Specify)	20b. Place of Disposer cometery, cr	position (Name of ematory or other place)	Date	20c. Location - City or Town, State
Balti	permit. Pages i Department of It Important: If its any injury or ot once.		21. Signatur Gunaral Strum Sicensee Ward	11 Well I	Baltimore, N	MD 21201	Baltimore Street
	Pnysician /Medical Examiner		28a. Part 1. Erier the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	inter the mode of dying,		rrest, Approximate Interval Between Onset and Death
,092	ted nsit	cal Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events c.	Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 68	i that the death certificate be execu- ted by the attending physician and detached for use as the burial-tra	Physician/Med	in the past 12 months?		B Ectopic pregnancy Description of the control of t		23d. Date of delivery Month Day Year
	juires that r signed b	by	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause given		tobacco use contribute to the cause of death?  Yes 2 540 3 Probably 4 Unknown
Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed				24a. Was auto perfc 1 □ Yes	
Vital	s certifica director,	To Be (	25. Was case referred to medical examiner?  1 Yes 2 Yes Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other	26. Place of Death (Check only	148
ion of	nding Phy th. :: After thi		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)  28b. Time Injury	Work?	at 28d. Describe	how injury occurred
Division	To the Hospitel or Attanding Physician: The I within 24 hours after death.  To tha Funeral Diractor: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Rural Route Number, wn, State)
)	e Hospit 24 hours a Funera	Medical (	(Check only 2 Medicel Exeminer: (	: To the best of my knowledge, de on the basis of examination and/or nd manner stated.	ath occurred at the time, investigation, in my opin	, date and place, and due to the nion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of Ontifier	>	29c. License r		29d. Date signed (Month, Day, Year)
•			30. Name and address of person who comple	ted cause of death (Item 23a) (Typ	e, Print)	036 0 Clost M	021619
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 8 2007	Registrar's Signature	anti)	-	<i>y</i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 02/23/2007 11:25A M Dolores Marie Wengert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death Examiner Baltimore Washington Med Ctr Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 06/05/1930 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗶 F 217-24-1339 76 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show 1 ☐Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or Items 23a or Medical Examiner must be 21122 122 Bar Harbor Road U.S.A. Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 72 hours after 1 ∐Yes 2 
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No laltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Proprietor Tavern Owner should be filed wand Mental Hygies marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) with and Mental F. Be 1 and 2 should be the Health and M Harry Raymond Marie Wager ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 929 Pier Point Drive, Pasadena, MD 21122 John Wengert / Son permit. Pages 1 a.
Department of Hea
Important: If item 2.
any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 02/28/07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter vie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of) Examiner Esophageal Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed (L) Breast Cancer burial-trar and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coronary Artery Disease 24a. Was an autopsy performed?

1 Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier l 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2

31. Date filed (Month, Day, Year) State FEB 2 8 2007 Registrar

8094 Edwin Raynor Blvd., Ste A, Pasadena, MD 21122 Nnaemeka Agajelu, 32. Registrar's Şignature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician

D56950

February 24, 2007

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7 23, Month **Physician** 2007 FRANCIS HAROLD WYATT February 7:44 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER Baltimore County Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Oct 5, 190 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1908 98 Maryland 216-03-2895 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 8820 Walther Blvd., Apt # 3201 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within th and Mental Hygiene. 7 Is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Harold Wyatt, Sr. Mary Louise Crouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Palma F. Wyatt (Wife) 8820 Walther Blvd., #3201, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott
once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 2/27/2007 Baltimore, Maryland 21. Signatur of Fundal Service Curren

Martin D. Lawson MINCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician +++ e655 /Medical Due to (or as a consequence of): Examiner Ischemic 650 Sequentially list conditions, Due to or as a conse juence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21300 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) NV5, VC 1 ☐ Yes 2 ☐ 🗡 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation To the mosphers after death.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00051926 2007 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Gordan 6565 P Charles St AS 203 21204 31. Date filed (Month, Day, Year) State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

			1- State of Maryland State of Maryland	/ Department of Health and Mer Certificate of Death	ntal Hygiene Reg. No.2 007 06076
	Physici	an	1. Decedent's Name (First, Middle, Last)  If A TRIDING MATELLINA CONVINED LIGHT		Date of Death Month Day Phruary 25 2007 8:45 PM
	/Medio Examin		KATHRYN MATILDA SNYDER WOEL  4a. Facility Name (If not institution, give street and number)  Franklin Square Hospi	4b. City, Town, or Location of Death ROSEDALE	Baltimore
	Funeral Director		5. Social Security Number 202-14-6765 6. Sex 1 □ M 2 ▼ 7. Age (In yrs. Ias	st birthday) Yrs.  If Under 1 Year Days Hours Min. M M M	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania
	yiand		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	10d. Inside City Limits
3	in the Maryland or 28a-f ehow e notified at	Director	Maryland Baltimore County	Parkville	1 □ Yes 2X No
			10e. Street and Number 2610 Edgewood Avenue	10f. Zip Code 21234	10g. Citizen of What Country? USA
ath R 41, 215-6036	within 72 hours after death with ene. ene. then "natural", or itema 23s of the Medical Examinar must be	by Funeral	11. Marital Status  1 Never Married  2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specity: White
15-0	"natu	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
212		omp	Elementary/Secondary (0-12) College (1-4or 5+)	Retail Sales Clerk	Department Store
⊆ ;	2 should be filed and Mental Hygis is marked other eumatic event, in	Be	17. Father's Name (First, Middle, Last)  Ivy C. Snyder		irst, Middle, Maiden Surname)
N Z	should be and Mental is marked of sumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)	Gertrude  19b. Mailing Address (Street and Number or Rural Re	Raymond oute Number, City or Town, State, Zip Code)
N.	ges 1 and 2 should t of Heelth and Mer If item 27 is marke or other treumatic		Dennis J. Stillwagner (Son)	909 Jessica's Lane, Bel	
Son	Pages 1 and nent of Heelth int: If item 27 iry or other tr		L Dullat 2 (Xicientation 3 Linemoval nom State )	ce of Disposition (Name of netery, crematory or other place)	
UN Baltimore	permit. Page Depertment of Important: If eny injury or once.		4 Donation 5 Other (Specify)  21. Signature of Fundal Server Liver see	en Mount Crematory 3/1/2  Name and Address of Facility ELD F	2007 Baltimore, Maryland FUNERAL HOME, INC.
<u> </u>	80 5 8	118	Martin D. Lawson	6500 York Road, Bal	timore, Maryland 21212
	hysician		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac of re	Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  Due to (or as a conseque	nce of):	
	- Xaiiiiiei	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	nce of):	
	ocuted nd transit	Examiner	that initiated events C.		
68760,	ficate be executed physicien and is the burial-transit	edicai Ex	resulting in death) Last  Due to (or as a conseque	nce of):	
x 68		Medi	IF FEMALE:		
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. After this certificate has been signed by the ettending to the the tending to completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
rds, P	w requires tha been signed I should be det	ρ	Part II. Other significant conditions contributing to death but not result Congestive Heart Fall	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Division of Vital Records,	The law resete hes been page 2 sho	Completed	U		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Vita	ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (C	
٥٠	iling Phys 7. After this funeral di	n: To	27. Manger of Death 28a. Date of Injury 2	VOutpatient 32 DOA 4 Norsing Home	5 ☐ Residence 6 ☐ Other (Specify)  Describe how injury occurred
sior	tandin leath. tor: Aft the fun	catio	2 Accident investigation	M 1 Yes 2 No	
Divi	efter d efter d Direct d in by	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attan within 24 hours efter deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl on the basis of examination and manner stated.	ledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
		Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	7		1 Cirons	DØØ63Ø54	february 25, 2007
8			30. Name and address of person who completed cause of death (Item 2 Majid Cine, no, 9000 Franklin Squa	ne Drive, Baltimane, Maryl	and 21237
	Sta Registr		Majid Cinc, no, 9000 Franklin Squa  31. Date filed (Month, Day, Year)  FEB 2 8 2007  32. Sistrar's Signatu	1. fresh	

			For State Registrar		State of M	laryland		artment					giene, Reg. No.	200	7	06077
			Decedent's Name	(First, Middle, La	st)							2. Date of De			<u>.</u>	3. Time of Death
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2	/Medic Examir		4a. Facility Name (If I	not institution, giv	e street and number			4b. City,	Town, or	Location	of Death	- CAUCA	4c. (	County of D		0.01.5
1	exa		Johns Had	Kilns Ro	yview Med	diral 1	Conter	1	3aH	t'm o	re					
	Funeral		5. Social Security Nu	mber 6. S	Sex 7. A	ge (In yrs. la	ast birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	th Voor	9. 1	Birthpla	ace (State or Foreign
	Director		216-03-00	)88 1	Mg M 2□ F	90	Yrs.	Months	Days	Hours	Min.	(Month, Da 01/1	2/191	L7 PA	Count	ry)
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	Ba-f	ç	MD	Baltimo	ore	Dur	ndalk							·		
	be filed within 72 hours after death with the Maryland ital Hygiene. of other then "natural", or items 23s or 28s-f show event, the Madical Examinar must be multified.	Funeral Director	10e. Street and Numl					10f. Zip	Code 222					en of What	Count	ry?
	s 23s	rai	1607 Rita	Ra.	1								USA			
	er de litem	nu	11. Marital Status	d OF Market	12. Was Decedent	?	5. 13.	If Yes, spec	ent of His	spanic Or n, Mexica	igin? (Spe n, Puerto	icify Yes or No Rican, etc.)	•   1	<ol> <li>Race - A Black, W</li> </ol>		
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	illed Hygid other	BeC	17. Father's Name (F	irst, Middle, Last	)					18. Moth	er's Name	(First, Middle,	Maiden S	Sumame)		
a	ould be fited with Mental Hygiene arked other the atic event, the b	To B	Byron W	ingert						Est	ell	Cole				
Maryland	S P E E	-	19a. Informant's Nan		• •		19b. Maili	ng Address	(Street a	nd Numb	er or Rura	l Route Numbe	er, City or	Town, State	в, <i>Zip</i> (	Code)
	and 2 Belth a n 27 le		Mary Prit	:chard/Da	ughter		3220	Bayo	nne	Ave	Tows	on, MD	2120	4		
ore	of He of He item		20a. Method of Dispo				ace of Dispo	osition (Nam	ne of	9)	С	Feb 26	20c. Loc	cation - City	or Tov	vn, State
Ĕ	Pages nent of I ont: If it			Cremation 3 ∟ 5 ☐ Other (Specif	]Removal from State (y)	9	cred F			1		2007	, Ma	ryland	d	
Baltimore,	글론판금.		21. Signature of Fun	eral Service Lice	nsee		2	2. Name and	d Addres	s of Facili	ity	l Alter	+i			
m	Depa Impo eny ii		2 1	, Due 5	Kither N	10144	3	8717 G	reen	Past	ures	Drive B	Balti	more,	Mar	yland 21286
			23a. Part1. Poter the	disease, or com	plications that cause one cause on each	d the death	. Do not en	ter the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (F	inal		olosi	<u> </u>									Onset and Death
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ó	e exe ien a irial-l	Ä	resulting in death) La	ist	Due to (or as	s a consequ	ence of):									
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	ing pl	Med	IF FEMALE:													
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of Vital Records,	Physician: this certific ral director,	Be	25. Was case referre examiner?	d to medical	Hoopitali a d				100		of Death	(Check only o	ne)			
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	ding I h. Alter funer	o	27. Manner of Death 1 Natural	5 Pending	28a. Oate of Inj (Month, Da	ay Year)	28b. Time o Injury		Bc. Injury Work			28d. Describe I	now injury	occurred		
Sic	tent for: the	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not b		iva. At ba		М		'es 2 🗌		Of Leasting /	24		0 /	
Division	i or Attendated after death	Certification:	4 Homicide	determined	28e. Place of In building, e	tc. (Specify)	) arm, su	reet, factory	, опісе		1	City or Tox	vn, State)	ivumber or	nurai	Route Number,
	pitel burs a leral		29a. Certifier 1	Certifying Pt	nysicien: To the best	of my know	vledge deat	h occurred :	at the tim	o date as	nd place of	and due to the	2000(0)			
	24 h 24 h Fun etely	edicai	(Check only 2	Medical Exar	niner: On the basis of	of examinati	on and/or in	vestigation,	in my op	inion, dea	ath occurre	ed at the time,	date and	place, and c	as sta due to t	ted. the cause(s)
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely tilled in by	Me	29b. Signature and ti	itle of certifier		11 1		29c.	. License	number			29d. Date	signed (Mo	onth, D	ay, Year)
	- SFO		1	1/1//	1	$/\eta - D$			RF	5-1	000	)	0	2/21	1	)7
/	1		30. Name and addres	ss of person who	completed cause of	death (Item	22a) (Tuno	Print)	10	1				100	1	1.0
(	e		Amar	dal	Han	, M.	1)."	194C	E	asta	em	AVE	nie	Bal	tin	rore, MI) 2001
	Sta	ite	31. Date filed (Month		32. Regist	rar's Signati	ure /	4			-	- (00		7	113	
	Registr		FE	B 2 8 20	07 Season	J. S.	600	all								
							40									

Amend #11, perFD, g855, 3/26/07 II State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5 Per FH G865 3/09/07 antificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30, 2007 4:42ам January Wyche Beatrice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 6615 Insey Street District Heights If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. May 1, 1927 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number **Funeral** 1 □ M 2 □ F <del>-226</del>-32-5667 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Maryland | Prince George's District Heights Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 238 6615 Insey Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ØNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 'naturel', or Items 11. Marital Status African Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American 3 X Widowed 4 □ Divorced þ Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) Private Social Worker permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any njury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Brown Jessie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Midnight/Granddaughter 6615 Insey Street, District Heights, Maryland20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jones Family Cemetery 2-03-2007 Freeman, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Sacility pope / P.A. 5538 Mariboro Pike/Forestville, Md. 401055 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Un Known /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-transit certificate be executed and Due to (or as a consequence of): attending physicien P.O. Box 68760 Physician/Medical IF FEMALE: esn n 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 1 ☐ Yes 2 X No 9 Unknown 9 Unknown is been signed by the should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☎ No 24a. Was an autopsy performed? 1 Yes 2 No if or Attending Physician: after death. Director: After this certifice 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Mannarof Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of conti 29d. Date signed (Month, Day, Year) 29c. License number 7,30107 41 0 Registrar's Signature 32 State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:55 AM FEBRUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-12-9943 Director 83 04/19/1923 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Riviera Beach 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 224 Glen Road 21122 U.S.A. Funeral h and Mental Hygiene. 7 is marked other than "natural", or Items : traumatic event, the Me Acal Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Mayes 2 No 1943 — If Yes, Give Year or Dates: 1945 Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Material Handler Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Valentine Yingling Elizabeth Susanna Monath 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mary Yingling / Wife 224 Glen Road, Riviera Beach, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem 03/01/07 Crownsville, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA Riviera Drive, Riviera Beach, MD21122 169 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** dein disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 □ Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an LIVE SHUCK 1□ Yes 2 1 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2000 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. Division or Vital Records, P.O. within 24 hours aries .....
To the Funeral Director: Aff

31. Date filed (Month, Day, Year) FEB 2 8 2007

29a. Certifiei

(Check only one)

29b. Signature and title of certifier

The Houthil

RES 00

1 Certifythg Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOTTARTHIL, 3001 SOUTH HANNOVER STREET, BALTIMORE, ND

Registrar

		ı	1 - For Stata Amend #PI line b	State of Maryland / D PII, 25, 27, 28a-f, <sub>1</sub>	Department of H <b>©e™ific&amp;te of</b> 4	lealth and M 190407h TT	lental Hygie Reg.		06080
200	Physici		1. Decedent's Name (First, Middle, Last) Lorene Anderso	n			2. Date of Death Month Eel-Dary	Day Year	3. Time of Death
	/Medic Examin Funeral Director		5. Social Security Number 6. Sex	Spike Center 7. Ago (In yrs. last bird	Chere	If Under 24 Hrs. Hours Min.	7	4c. County of Death	NALS  lace (Sate or Foreign tity)  ThCarolina
	פ	tor	Usual Residence of Decedent  10a. State 10b. County  D • C •	10c City, Town Washi	n or Location ngton		Daily 20,		Od. Inside City Limits  1 XYes 2 No
	with the 3a or 28a-	I Director	10e. Street and Number 318 Seaton Pla	ice N.E.	10f. Zip Code 20001			. Citizen of What Cour	ntry?
-0036	4 within 72 hours after death with the Maryland liene. I than "neturel", or items 23a or 28a-f show the Medical Eranil or must be collified at	ed by Funeral	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced  15. Decedent's Edu	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No II Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No Decedent's Usual Occup.	Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc. Ck
21215-0036	within ene. then	Completed	(Specify only highest grade	e completed)	(Give kind of work done of life. DO NOT use retired Spiratory	during most of worki i)	ng	Hospital	ausii y
land 2	be filed ital Hyg od othe event,	To Be C	17. Eather's Name (First, Middle, Last) Clarence Kenne	dy			(First, Middle, Mai Sistron	,	
Maryland	2 sho and is m		19a Informant's Name/Relationship (Ty Anthony Anders	pe, Print) On- Son	Mailing Address (Street & 318 Seaton	and Number or Rura Place N	al Route Number, C	ity or Town, State, Zip	Code) 20001
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter	Disposition (Name of y, crematory or other place Colivet	[	Date 200	c. Location - City or To	wn, State
Balt	permit. Pag Department Important: It eny injury o		21. Signature of Funeral Service Ligens	opinen).	Robinso	ss of Facility n Funera	l Home	h 1313 <sup>D</sup> 6Eh	20001 St.NW
1	Physician /Medical Examiner		23a. Pary. Enter the disease, or complisted, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not be cause on each line.  Atheros Cless  Due to (or as a consequence of the constant of th	Tic Cardio				Approximate Interval 8etween Onset and Death
68760,	ificate be executed g physician and as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or as a consequence of Due to (or					
О. Вох	death certif e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	sign d be		Part II. Other significant conditions cor <b>Ankle fracture</b>	stributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	_
of Vital Record	The law ate has b page 2 si	Completed					24a. Was an autopsy performed	d? prior to cor death?	osy findings available inpletion of cause of
/ita	Physician: T this certificat ral director, p:	Be	25. Was case referred to medical examines?			26. Place of Death	(Check only one)		
of	Physic this o	P	765 Z NO	lospital: 1 Inpatient 2 ER/Out		4   Nursing no		e 6 ☐Other (Specify	")
	ing After une	0	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		njury Work	K?	28d. Describe how i	injury occurred	
Sic	Attending r death. ector; After by the fune	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Nov. 18, 2006 unk			subject fel		
Division	il or Attend after death   Director; / d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		City or Town, S		
	Hospita 14 hours Funeral tely filled	edical C	(Check only 2   Medical Examin	Bus Bathroom  sician: To the best of my knowledge ner: On the basis of examination and	, death occurred at the time.	ne, date and place,	and due to the caus	ty, New Jers (s) and manner as st and place, and due to	ated.
	To the Within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c. License			Date signed (Month,	
	00	W	Androdo 10	thester Do	Ho	5132			
- /	70		30. Name and address of person who co	mpleted cause of death (Item 23a) (	Type, Print) Spital D	hine C	Par 20	Mary las	. 1
	Sta	te	31. Date filed (Month, Day Year)	32. Registrar's Signature	51100	,	- voy	MAY 1A	
	Registr		LER 14 5001	en p. poul	7		U		

		ľ	For State Registrer	State of	Marylan		artment of H		d Mental Hy	giene Reg. No:		06081
E	Physici		Decedent's Name (First, Middle,     Dennis	Last) Ann	Bla	ke			2. Date of De Month Feb. 8	ath Day	Year	3. Time of Death 9:20p M
	/Medic Examin		4a. Facility Name (If not institution, 8820 Woodlan	give street and numb			4b. City, Town, o	Sprin	eath 1g	4c.	County of Oeath Montgom	*
	Funeral Director		5. Social Security Number 419-60-5029  Usual Residence of Decedent	. Sex 7 1 □ M 2 🔀 F	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	th ly, Year) 20, 1	9. Births Cow 946 Ala	place (State or Foreign ntry) abama
	death with the Maryland ime 23a or 28a-f ehow firmet be notified at	tor	10a. State 10b. County MD Montg	omery	1	, Town or Lo	Spring				1	10d. Inside City Limits
	th with the 23a or 28	ai Director	10e. Street and Number 8820 Woodland	Drive			10f. Zip Code 209	10		10g. Citiz	zen of What Coul USA	ntry?
920	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel; or Itema 23a or 28a-f ehow event, the Musical Exaction must be collified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es?	-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗷 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		14. Race - Americ Black, White, Specify:	
1215-0036	within 72 hours after ene. then "naturel", or ite	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of d)			nd of Business/In	ontractor
land z	D 2 2 0	To Be Co	17. Father's Name (First, Middle, La Ralph Mosely	ast)			anciai	18. Mother's I	Name (First, Middle na LaTu		Sumame)	
re, mary	s 1 and 2 shoul of Heelth and M item 27 is mark other traumati		19a. Informant's Name/Relationshi Michael A.Bla 20a. Method of Disposition			882		and Dr	Rural Route Numb	ver		,Md.20910
IIIImore	nit. Pages artment of l ortant: If it injury or o		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Light Service Ligh	city)		esape	ake Cre	m. 2/1	0/2007 DI FUNE	Be]	ltsvill	e,Md.
8/6U, Francis Bal	Do Cate be executed by Sician and Medical Examiner.	dicai Examiner	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate automatic and the conditions of th	a. Ren Due to (o b. Met Due to (o	ch line. 1al Fa ras a consequ	ilure uence of): ic Ca uence of):	241 Colliner the mode of dying	umbia ng, such as card	Blvd.Si	lver	Sprin	G. Md 20910 Approximate Interval Between Onset and Death
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ords, P.	w requires that the di been signed by the should be deteched	þ	Part II. Other significant condition	s contributing to dea	ith but not resi	ulting in the u	nderlying cause giv	ven in Part I.		obacco u Yes 2		he cause of death?
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ion of Vit	To the Hospital or Attending Physicien: T within 24 hours effer death. To the Funeral Director: Affer this certificet completely filled in by the funeral director, p	ation: To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ⋈ No  27. Manner of Ceath  1 ⋈ Natural 5 □ Pending convestigation investigation.	28a. Date of (Month	patient 2 Injury Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	ner: 4 Nursin	g Home 5X Resi 28d. Describe	dence 6		ýy)
Division	Hospital or Atte     At hours efter des     Funeral Directo etely filled in by th	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place c	of Injury - At ho g, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or Rura )	al Route Number,
	the Hosp nin 24 hou the Funa npletely fil	Medical	(Check only 2 Medical E	Physician: To the base and manner	sis of examinat	wledge, deat tion and/or in	vestigation, in my	ppinion, death o	ace, and due to the courred at the time,	date and	place, and due to	the cause(s)
	To the vithin compl		29b. Signature and title of bentuer  30. Name and address of person w	HAULU ho completed cause	of death (Item	1 23a) (Type	Print)	216C	7		e signed (Month, 0.10,20	
	S.	nto-	Petr Hausne 31. Date filed (Month, Day, Year)	r MD 5	408 Re	oosev	elt St.	Bethe	sda, Md	208	17	
	Sta Registi		FEB 1 2	2007	ever l	4 A	and I					

Registrar DHMH 17 Rev 1/2001

State

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9901 Medical

egistrar's Signature

			1 - For Registrar	State of Man		artment of H		-	giene Reg. No.	007	06083
7	Section.		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici		Rita Marjorie Bego	sh				Februa:	Day rv 10.	Year 2007	5:50am M
k	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or	r Location of I			ounty of Deat	
		4	Shady Grove Advent	ist Nursin	o Center	Rockvil:	le		Мо	ntogme	rv
15	Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9. Birtl	hplece (Stete or Foreign
£ 300	Director	ß.	577-46-9214	M 251F	86 Yrs.	Months Days	Hours	Min. (Month, De May 8,	1920	Penr	uintry) nsylvania
	2		Usual Residence of Decedent								
	rylar	_	10a. State 10b. County	10	Oc. City, Town or Lo	ocation					10d. Inside City Limits
	Bo-f	cto	Maryland Montgomery	7	Rockvill	e					1 X Yes 2 No
	or 21	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Co	untry?
	23a		1203 Highwood Road			20851			Unite	d Stat	es
	ems Fr	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14	. Race - Ame Black, White	
99	or it		1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ဩ No	Specify:		S	pecify: Whi	
Ö	72 hours after death with the Maryland neturel', or items 23a or 28e-f ehow Jical Examinat must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:							
21215-0036	net ride	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done	during most o	f working	16b. Kind	of Business/	Industry
12	within ene. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	•		N	•	
7	at Hygie other vent, II		17. Father's Name (First, Middle, Last)	3	Regis	tered Nu	_	Name (First, Middle	Nurs		
and	be do be	Be							, Maidell St	21/1/21110/	
Ĕ	2 should be I and Mental I is marked o	1º	Frederick Homnick  19a. Informant's Name/Relationship (Type	an Drinel	10h Maili	4 d d (0		on Jones	C*T		T- (1-1-1
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene 1 health and Mental Hygiene 1 health and Mental Hygiene 1 health at 1 is marked other than "neture!", or items 23a or 28a-1 ehow other traumatic event, its Medical Eraining must be notified at							or Rural Route Numb			
e,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra	(8	Andrew Joseph Bego 20a. Method of Disposition					Avenue, B		ville,	
Baltimore,	iges if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other place				•	
ξ	t. Pa tmer tant njury	. 9	'4 □Donation 5 □ Other (Specify)								, Virginia
Bal	Depariment of the policy of th		21. Signature of Funeral Service License	3.0/1	$1 \stackrel{2}{1}$	2. Name and Addres .O East De	ss of Facility	DeVol Fun rk Drive	eral	Home	
	GU 2 6 0		Yourk IN- in	wit		0 East De Gaithersbu					
			23a/Part1. Entér the disease, or compli shock-or heart failure. List only on	e cause on each line	death. Do not ent	ter the mode of dyin	g, such as ca	irdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		) ~				
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	D #	Examine	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequènce d'):						
	and tran	Саш	Cause (Disease or injury that initiated events cresulting in death) Last	. Due to /or on a	2000 at 1000 at 1000						
8760,	cate be executed ohysician and the burial-transit			Due to (or as a co	onsequence or):						
87	ohysie the b	Physician/Medical	d								
9	death certific e attending p id for use as	Me	IF FEMALE:	2. #							
Вох	ath c	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			230	<ul> <li>Date of deli</li> <li>Month</li> </ul>	very Day Year
0	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5	Other (specify)				THO INT	ouy ou
<u>a</u> .	ac ac	F.	Part II. Other significant conditions con	tabuting to dooth but a	at ranultina in the		na in Donal	22a Did	abassa usa	anntributa ta	the enuse of death?
JS,	es pe	þ	Part II. Other significant conductis con	thouting to death out in	or resulting in the o	riderlying cause give	en in Fait I.				the cause of death?
orc	w requires been sign should be	ompleted						_   '''	Yes 2.⊿1	40 3 FIG	Solution 4 Donkhown
ec	2 2	JQ.						24a. Was		24b. Were au	topsy findings available completion of cause of
<u> </u>	Th ate pag	Con						perfo	rmed? 2 2 No	death? 1 ☐ Yes	
ita	iclan: certifica rector, p	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	ne)		
of Vital Record	S S	2	1 ☐ Yes 2 ☐ NO	ospital: 1   Inpatient	2 ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursi	ing Home 5 Resid	dence 6	Other (Spec	cify)
		ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	f 28c. Injun Worl	at k?	28d. Describe	now injury o	occurred	
Ö	Attending r death. sctor: After by the fune	atle	2 Accident investigation				Yes 2 □ No				
Division	I or Atten after deat Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	eet, factory, office		28f. Location (3 City or Tox	Street and N vn. State)	vumber or Ru	ral Route Number,
0	• Hospital or A 24 hours after • Funeral Dire- letely filled in by	Cer						Ų.			
	ospi houn uner lly fill		29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, deat	h occurred at the tim	ne, date and p	place, and due to the	cause(s) an	nd manner as	stated.
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical	one)	and manner stated		vestigation, in my of	pirnori, deatir	occorred at the time,	uate and pi	ace, and doe	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	-62	29d. Date s	signed (Month	n. Dey, Year)
,						MO	>85	> (+	01	-10	- o t
	الآ		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type.	Print) /50	5 5	KAY GOOR	RI	Sur	¥ 200
			Orlahryar (	javaci.	OM.	Roc	ixuille	CINO	20	078	0
	Sta Registr		31. Date filed (Month, Day, Year)  FFR 1 2 200	32 degistrar's	Signature	2000		, , ,			

			1- For State of Maryland / Department of He Registrer Certificate of D		Z 11 11 / 11 b 11 b 14
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Н	Physici /Medic		George W. Burley	Month I	9 Year 7:55A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	4c. County of Death
			Devlin Manor Cumber		Allegany
	Funeral		5. Social Security Number 159 - 14 - 2882 10 M 2 F 7. Age (In yrs. last birthday) 1 F Vrs.  1 Yrs.  1 Yrs.	Hours Min. 8. Date of Birth (Month, Day, Yes	
	Director		Usual Residence of Decedent	3-12-19	115 PA
	ylanc		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-f e	ctor	MD Allegany Corriganville		1 🔏 Yes 2 🗆 No
	ter death with the Marylan Items 23s or 28s-f show Instribust be notified at	Dire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	a 23a	rai	12513 Jennings Way 21524		USA  14. Race - American Indian,
	iten de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Never Married 2 Married  12. Was Decedent Ever in U.S. If Yes, specify Cubar	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)	Black, White, etc.
920	urs af	þ	1 Never Married 2 Married 1 Yes 2 No II Yes, Give 1 Yes 2 No II Yes, Give 1 Year or Dates:	Specify:	Specify: White
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. ed other then "natural", or items 23s or 28s-f ehow event, the Medical Examinal must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done di	tion 16b.	Kind of Business/Industry
21	ithin and	nple	Elementary/Secondary (0·12) College (1-4or 5+) life. DO NOT use retired)	aring most of working	
121	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	umber
and	d be f	9Be	William Nelson Burley		
Maryland	should nd Me mark imatic	2		Orpha Blanche nd Number or Rural Route Number, Cit	
	nd 2 alth a 27 is r treu				anville, MD21524
Baltimore,	ss 1 an of Heal item 2 r other		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or Town, State
Ë	Page nent ant: fi		4 Donation 5 Other (Specify) Cooks Mills Cem	eteru -6-2007 Hu	ndman. PA
Salt	permit. Pages: Department of H Important: If Ite any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address	of Facility Harvey H.	Zeigler Funeral
	<u>7</u> 0 ≥ € 0				Hyndman PA 15545
Q		0 10	23a. Pan . Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  Dementia		Unknown
	Examiner		Due to (or as a consequence of):  Congestive Heart Fail	u h o	unknown
	- 19	Jer	if any, leading to immediate Due to (or as a consequence of):	une	97HC1-0001
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.		
,092	sician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
876	A > 0	dlcai	d		
89 X	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
o.	at the de by the a	hysi	9 Unknown		
ď,	es thei igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives	n in Part I. 23e. Did tobacc	o use contribute to the cause of death?
ğ	w require been sign	ted	Aspiration Pneumonia	1 ☐ Yes	2 No 3 Probably 4 Munknown
Division of Vital Records,	a 25	Completed	Hypertension	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E H		Con	Coronary Artery Disease	performed 1 ☐ Yes 2 🕰	
Vita	Physician: T this certificet ral director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
ot	Phy this ral di	: To	1 Inpatient 2 Envoutpatient 3 DOA	4 Manualing Hollie 3   Residence	
on	Attending Phradeling Phradeling Phradeling Sctor: After this by the funeral	ıtlor	1 Matural 5 Pending (Month, Day Year) Injury Work	? es 2 □ No	,,
vis	il or Attendi after death. Director: A d in by the fu	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
۵	tal or rs afte al Dir ed in	Certification:	4 Homicide building, etc. (Specify)	City of Town, St.	210)
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by ti	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my op	e, date and place, and due to the cause inion, death occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the Mithin 24 To the Foomplet	Med	one) and manner stated.  29b. Signature and title of a differ 29c. License		Date signed (Month, Day, Year)
<b>\</b>	3		A dilling		
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	60478 2	-6-2007
	nus		Afag Ahmad 625 Kent Ave., Cumberland.	MD 21502	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Parties and the control of the process of the second	
	Registr	ar	FEB 0 6 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 2007 10:53 AM FEBRUARY 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Boutinore C If Under 1 Year If Under 24 Hrs. Hopkins Hospital
Sex 7. Age (In yrs. last birthday) Johns 14 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 216-72-5275 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. tnside City Limits ir then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Allegany Director Ellerslie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10106 Humming Dird 215 Z9 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or Itema 23e eny highry or other treumatic event, the Medical Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: Whi 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) TRUCKING TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Burgess Carroll Eugene
19a. Informant's Name/Relationship (Type, Print) varoline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2-17-07 Johnstown Cremetory 4 ☐ Donation 5 ☐ Other (Specify) Johnstown 21. Signature of Funeral Service Licenses 22. Name and Address ThicilityHARVEY H. Zeigler Funeral Home Clarence St Hyndman PA 23a. Part 1 Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) FND AGE Physician TWO MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as tF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 pronths? Day 5 Other (specify) 9 Unknown 9 Unknown NIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funarai Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Xnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Karry completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

ORIGINAL

NORTH

WOLFE STREEL BALTIMORE, MARPLAND 21287

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 👂 🗎 🧻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 Day 2007 Year **Physician** 12:30 P M James F. Brown, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 18, 1923 9. Birthplace (State or Foreign **Funeral** 1 x M 2 □ F Maryland 579-12-0017 83 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "naturel", or Items 23a or 28s-f shows ovent, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD Worchester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10302 Timberlake Court 21842 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 GYes 2 □ No WWII If Yes, Give WWII Year or Dates: 21215-0036 1 □ Yes 2 No Specify: þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. Customer Engineer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Frank Brown, Sr. Lillian N. Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Heelth ar
Important: If Item 27 ie
ony injury or other treu James Brown, III / son 35 Alton Point, Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. Feb. 21, 2007 Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Fruice Lisensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 1 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, 1 any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiqian: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this curtificate has been signed by the attending physicien and completely filled in by the ithorest director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 Be 25. Was case referred to medical 26. Place of Death (Check only one examiner?
1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Bown Jr 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W0064585 Feb.8, 2007 15+1 way Drue Berlin MD 21811 State Registrar

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			For State	State of Mar				Mental Hygi	ene 007	06087
			1 - State RegistrarAmend# 3.Pe	rPhys.PGC 2	–20–07 <i>≿₁<sup>e</sup>′</i>	Tificate of t	Death	2. Date of Death	g. No.	3. Time of Death
30	Physici		Louis Anthony					Month Februar	Day Year	3:35-P. M
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	
3			Prince George's		nter	Chever]	_		Prince Geo	
	Funeral		5. Social Security Number 6. S	7. Age (	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		217–32–3554 Usual Residence of Decedent	09	115.			3/1/37	Wash	D.C.
	yland now		10a. State 10b. County		0c. City, Town or Lo	cation				10d. Inside City Limits
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	ith th	Director	10e. Street and Number			10f. Zip Code	20742	10	g. Citizen of What Cou	intry?
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural; or Items 23a or 28a-f ehow event, the Medical Examitier in that be invilled at	rai	6609 Seat Pleas		or in ILC 12.1	Man Donadont of U	20743	noothy Voc or No-	U.S.A.	ican Indian
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Maryland 21215-0036	d be sental ked o	To Be	Joseph Leo Wil	liams				ucille Fl		
ary	2 should be filed within 72 hours after death with the Marylan and Mantal Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Exprintment and be millified.	-	19a. Informant's Name/Relationship (	er i i					City or Town, State, Zi	p Code)
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altimore,	of He of He If iten		20a, Method of Disposition  1 ♣ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory`or other plac			0c. Location - City or T	
Ē	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify	)		Mem. Parl			Landover,	
Bai	permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licen	2. sau	4	Name and Addre H.S.Was 925 Burro	ss of Facility Shington Oughs Ave	& Sons Co	Inc. Inc.	.C.20019
\$. 19. <sub>40</sub>	4 k	8	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the						Approximate Interval Between
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o,	exect an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a d	consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai	(	d						
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Вох	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	very Day Year
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تِ	that the hold by detail	y Ph	Part II. Dther significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Division of Vital Records, P.O.	aw reas s bee	Completed						24a. Was an		opsy findings available ompletion of cause of
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on C	Attending Physician: or death. ector: After this certifica by the funeral director, I	ion	27. Manner of Death  1 ™ Natural 5 Pending  2 Naccident investigation	28a. Date of Injury (Month, Day )	(ear) 28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe how	w infury occurred	
isi	or Attendate death	fica	3 Suicide 6 Could not b	28e. Place of Injury	/ - At home, farm, str			28f. Location (Str.	eet and Number or Rui	al Route Number,
<u>S</u>	al or A s after ii Direct id in by	Certification:	4 Homicide	building, etc.	(Specify)			City or Town,	, State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
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150	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	20-1			0,10,10,0	1	, -
	Regist		FEB 14 2007 Ra	men M.	herde					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician $A^{\ M}$ 2007 February 8, 3:38 Sarah Brown /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Community Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🗓 F 249-52-8405 Yrs. 93 12/17/1913 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location or 28a-f show e notified at 1XXYes 2 □ No MD Lusby Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be r 1004 Cattle Drive Trail 20657 USA Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Black Baltimore, Maryland 21215-0036 Completed by 3 Midowed 4 Divorced natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Government 10th Service Worker 27 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gussie Hannah Simpson Brayboy ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1004 Cattle Drive Trail, Lusby, MD 20657 27 Sarah Adams/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or oth 1 XBurial 2 □ Cremation 3 □ Removal from State 2/12/07 Adelphi, MD Geo Washington Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 23à Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARTER CORONAR month **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the search of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnam 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed INSUFFICIEN CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 TLNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 3 DOA 1 🗌 Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 Tes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death To the Funeral Director:

State Registrar

Medical

30. Name and address of person who completed cause of leath (Item 21) (Type, Print) 31. Date filed (Month, Day, Year)

FEB 14 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature D. Sperte

110

and manner stated.

i vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

ste 303 Prince Frederick and zung

		-	For State Registrar	State of N	Maryland / De	epartment of Certificate			Hygien	24111/	06089
			1. Decedent's Name (First, Middle, L	ast)				2. Date Mon	of Death th Da	av Year	3. Time of Death
	Physicia /Medic		Doris Esther Bu	rdick				2	,11	1 2007	
	Examin	er	4a. Facility Name (If not institution, g		er)		wn, or Location	of Death		c. County of Dea	ıth
			2499 Fairmount 5. Social Security Number 6.		Age (In yrs. last birtho	Hampst		r 24 Hrs. 8 Date	of Birth	Carroll	thplace (State or Foreign
	Funeral Director			1□M 2∏F	74 Yrs	Months D	ays Hours	Min. (Mon	th, Day, Year, 16/193	)   0	ountry) cyland
	ס		Usual Residence of Decedent		, -				107		
	anytan show	_	10a. State 10b. County  MD Carroll		10c. City, Town of Hampste						10d. Inside City Limits 1 1 Yes 2 X No
	28a-f	Director	10e. Street and Number		Tiompo do	10f. Zip Co	odo.		10g Ci	itizen of What C	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-1 show parel Examiner must be notified at	Ö	2499 Fairmount	Road			074		_	ited Sta	•
	ms 2%	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Deceden	of Hispanic O	rigin? (Specify Yes	or No-	14. Race - Am	
9	or Ite		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 ☐ If Yes, Give		If Yes, specify  1 ☐ Yes 2		in, Puerto Rican, et	(c.)	Black, Whi Specify: Wh	
933	ural',	d by	3 Widowed 4 Divorced	Year or Date:				•			
15.	"nati	Completed	15. Decedent's (Specify only highest g		(0	ecedent's Usual C live kind of work of e. DO NOT use r	fone during mo:	st of working	16b. F	Kind of Business	s/Industry
12	d within 7. piene. r than "n ir e Medi	duo	Elementary/Secondary (0-12)	College (1-4c	or 5+)	emaker			Res	sidence	
b	Hyg the int,	a	17. Father's Name (First, Middle, Las	st)	1		18. Moth	ner's Name (First, A	Middle, Maide	n Sumame)	
<u>Jar</u>	Q 5 0 0	To B	John Baker				Myr	tle Lena	Vicke	rs	
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship		1			er or Rural Route	-		
	7.2 je d		Edward A. Burdic	k, Sr I		9 Fairmo		d, Hampst	-		
Baltimore,	m 0 L		20a. Method of Disposition 1 □ Burial 2 X Cremation 3		te cemetery,	crematory or othe	r place)			_ocation - City or	
ij	t. Partmer	4	*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		Carroll	Cremati					Maryland
Ba	permi Depa Impo any ir		) 21 (u)	FO	M00723			my Eline : mpstead, 1			934 South
	- 11		23a. Part1. Enter the disease, or co	mplications that caus	sed the death. Do not					.IQ 2107	Approximate Interval Between
	Fnysician		shock, or heart failure. List on Immediate Cause (Final disease or condition	meta.		prent	cano	091-		2	Onset and Death
	/Medical		resulting in death)	d	as a consequence of)						3 413 ,
	Examiner		Sequentially list conditions.	b							
	be sit	luei	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to [or	as a consquence of						
	be executed sictan and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or	as a consequence of)	;					
8760,	sician burit	dlcal E	l l	<b>.</b> d							
9	ifficate I g physi as the t										
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnancy 2 DFetal death	3 □Ectopic pregr	nancy			23d. Date of de	
	e deal	slcie	in the past 12 months? 1 ☐ Yes 2 💆 No		t at time of death	5 ☐ Other (specif				Month	Day Year
P.0	that the de led by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to death	h but not resulting in th	a underking caus	e gwen in Part	23e	Did tobacco	use contribute t	o the cause of death?
ds,	signe d be d	i by	Atrial Film	volla Hovi	), CUT	NOWY (	7 On Ha	). 200			robably 4 DUnknown
Ö	w requir been si should	Completed		(0)			O Train	342	. Whas an		utopsy findings available
Rec	The lav	dmo							autopsy performed?	prior to death?	completion of cause of
tal	<i>ta □ □</i>	a	25. Was case referred to medical	1			26. Plac	e of Death (Check	Yes 2 No	o 1 Tes	s 2 <b>2</b> No
of Vital Records,	di is	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 ☐ Inpa	atient 2 ER/Outp	atient 3 DOA	Other	ursing Home 5		6 Other (Spe	ecify)
	ng Ph fter th neral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of I (Month,	njury 28b. Tim Day Year) Inju		Injury at Work?	28d. Des	cribe how inju	ury occurred	
sio	Attendideath. ctor: A y the fu	catl	2 Accident investigat 3 Suicide 6 Could not	ha -		М	1 ☐ Yes 2 ☐				
Division	in ter	Certification;	4 Homicide	d 280. Place of	Injury - At home, farm etc. (Specify)	, street, factory, o	ffice		ation (Street a or Town, Stat		lural Route Number,
_	hours a uneral		29a. Certifier X Certifying	Physicien: To the be	est of my knowledge, o	leath occurred at t	he time date a	nd place, and due	to the cause(s	s) and manner a	s stated
	T 4 F F	edical	(Check only 2 Medicel Ex	aminer: On the basis and manner	s of examination and/	or investigation, in	my opinion, de	ath occurred at the	time, date an	nd place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	20 20			icense number			ate signed (Mon	
	M		• Afans	Q1 1011	)	D			2	-12-0	/
-1	J.		30. Name and address of person wh	o completed cause o		.71	) 1.	restmin	tos	mn 2	1157
	0		M. PANSURIYA 31. Date filed (Month, Day, Year)	349	istrar's Signature	w Di		(ZIIIIII)	1100	110 ~	
	Sta Registi		FEB 1 2 20	1		parke					
		-	FED 1 6 CL	SUST JURISTIN	N Pe						

			FOR	artment of Health and Mental Hygiene rtificate of Death Reg. No. 0 7 0 6 0 9 0
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  DRWN MARLE BAIRD  4a. Facility Name (If not institution, give street and number)	2. Date of Death  Month Day Year  OO 15 M  4b. City, Town, or Location of Death
\$ 15 m	Funeral Director		Carroll Hospital Center  5. Social Security Number  6. Sex  1 M 2 M 7 Age (In yrs. last birthday)  48 Yrs.	Westminster Carroll  If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 05 1958 MD
nd 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural, or Items 23e or 28e-f show int, the Madical Examiner must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lot  10b. Street and Number  5190 Feeser Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  15. Father's Name (First, Middle, Last)  16a. Decedent's Education College (1-4or 5+)  15. Father's Name (First, Middle, Last)	ocation 10d. Inside City Limits 1 □ Yes 2 □ No
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve QRC8.	To	19a. Informant's Name/Relationship (Type, Print)  Charles Baird/husband  20a. Method of Disposition  WB Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  19b. Mailia  5190  20b. Place of Disposition cemetery, creation to the complete of the	Lucille White  ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Feeser Road Taney town, MD 21787  ostion (Name of matory or other place) 2/10/2007  n Memorial Gardens Finksburg, MD  2 Name and Address of Facility  ritts Funeral Home and Chapel, P.A.
8760, B	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	112 Washington Rd Westminster, MD 21157 ter the mode of dying, such as cardiac or respiratory arrest,  AL INFARCTION 230 MIN
Box 6	it the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Pregnant at time of death 5 □ Pre	□Ectopic pregnancy 23d. Date of delivery Month Day Year
Records, P.O.	aw requires thats been signed as should be de	Completed by Ph	Track II. Other significant conditions contributing to death but not resulting in the d	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy
of Vital	ding Physician: The n. After this certificate h funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 FR/Outpatient 1 Inpatient 2 FR/Outpatient 3 FR/Outpatien	nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division	To the Hospital or Attendining 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier  1 Secrifying Physician: To the best of my knowledge, deal	reet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  th occurred at the time, date and place, and due to the cause(s) and manner as stated, exception in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the comp	Me	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number 29d. Date signed ( <i>Month, Day, Year</i> ) 2 - 9 · 0 7 Print)
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	houles

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		artment of H		nd Mental Hy	giene Reg. No 2007	06091
	Physici		Decedent's Name (First, Middle, Last)	ouglas Brown				2. Date of De Month		1001314
	/Medic Examin	er	4a. Facility Name (If not institution, give si Union Hospital  5. Social Security Number 6. Sex	treet and number)		4b. City, Town, or Elkton	Location of	Death	4c. County of Dea	
	Funeral Director			7. Age (In yrs. la M 2□ F 51	Yrs.	Months Days	Hours	Min. (Month, Da	2, 1955 P	ennsylvani
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f show the Madical Examiner must be motified at	ector	10a. State 10b. County MD Cecil 10e. Street and Number	10c. City	Nor	th East			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	ath with 1 a 23a or 3	rai Dir	3185 Turkey Po			2190			USA	
9036	ours after de ral', or item Examiner o	I by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2√☐ No	spanic Origin, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)	Specify: W	te, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examination must be notified at ODGe.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 1 2	ation completed) College (1-4or 5+)	(Give life. l	dent's Usual Occupa kind of work done o DO NOT use retired rpenter	turina most i	of working	16b. Kind of Business  Constru	
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  Raymond H.			_	Je	's Name (First, Middle	bley	
, Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type Dixie Hughlett,	sister	2794	6 St. Mi		l's Rd.,	er, City or Town, State, Easton,	MD 21601
Baltimore,	Pages 1 Iment of H tent: If Iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sout	metery, crer ch Ca	sition (Name of matory or other place rroll Ci	remat		Winfiel	
Ba	Departiment Important in Suny in Suny in Suny in Suny in Suny in Sunce.			M0119	7 1	<u>91 Willi</u>	is St		nster, MD	21157
	Physician /Medical Examiner	Examiner	23a. Pagl. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	vence of):	Failur		ardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medicai E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	ncy death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	w requires thet the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	tributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.		tobacco use contribute t Yes 2 □ No 3 1 F	to the cause of death?
al Reco	: The law receive has been page 2 sho	Completed							an 24b. Were a prior to death? 2 \(\infty\) No 1 \(\infty\) Ye	utopsy findings available completion of cause of
f Vita	Physician: The l this certificete ha al director, page	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital: 1 ☐ Inpatient 2 💢	ER/Outpatier	nt 3 DOA	200	of Death (Check only sing Home 5 - Res	one) dence 6 Other (Spe	əcify)
Division of Vital Records,	After After funer	Certification:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time or Injury	M 1	/at <br Yes 2 □N	28f. Location	how injury occurred  Street and Number or F	lural Route Number,
á	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide  29a. Certifier  1 X Certifying Phys	building, etc. '(Specify		h occurred at the tim	ne, date and		wn, State) cause(s) and manner a	s stated.
	o the Ho ithin 24 h o the Fur ompletely	Medical	(Check only 2 Medical Examination)  29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my of	pinion, death	h occurred at the time	date and place, and du 29d. Date signed (Mon	e to the cause(s)
	WIL		1/ Neglil			000	628	328	2/9/0	7
	8		30. Name and address of person who co	de	Uni	14	spita	1 . ELKTO	N, MD	21921
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 2 2	32. Registrar's Signal	St.	South !				

DHMH 17 Rev 1/2001

ORIGINAL

			-	State	of Ma							ental Hy		e	9.510.		
			1 - For State Registrar			, , , , , ,	•			Death			Reg. N	91	007	06	092
	Dhysisi		1. Decedent's Name (First, Middle,	Last)								2. Date of De	ath Da	av	Year	3. Time	of Death
	Physici /Medio		Clibable 13	· Lpst								Month		7-	2007		a. M
)	Examin	er	4a. Facility Name (If not institution,	1 1	1 1.	_		Λ		Location o	of Death		40	Λ	nty of Death	1 show	
	Funeral		11/2 ams 14	educh (	7. Age	(In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of Bi	rth .	400	9. Birth	place (State	or Foreign
	Director		081-30-4636	1□M 2□ X	F	67	Yrs.	Months	Days	Hours	Min.	May 29	19, Year	939		ntry) York_	
	pus *		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside	City Limits
	Maryl	lor		rundel			apolis										s 2 No
	r 28a	Director	10e. Street and Number	.r under		AIIII	аротть	10f. Z	p Code				10g. C	itizen	of What Cou		
	th wit	alD	980 Riversedge 0	ircle		_		2	1401				Uni	Lte	d Stat	es	
	ar des	nue	11. Marital Status	Armed	Decedent E 1 Forces?		.S. 13.	Was Dece If Yes, sp	dent of Hi scify Cuba	ispanic Orig n, Mexican	gin? (Spe i, Puerto	city Yes or No Rican, etc.)	o-		Race - Ameri Black, White,		
36	I', or	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ②XDivorced	If Yes	es 2∭X∏N ,Give orDates:	0		1 🗆 Yes	Ž∏ No	Specify:				Spe	city: Wh	ite	
Ö	within 72 hours after death with the Maryland ene. than "naturel", or tlame 23a or 28a-f show ta Marical Examinat must be motified at	ted	15. Decedent's	Education			16a. Dece	dent's Usi	al Occupa	ation during most	e of worki		16b. I	Kind o	f Business/Ir	ndustry	
Maryland 21215-0036	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)		e (1-4or 5	+)	life.	DO NOT	ise retired	) ()	I OF WORK	ng					
2	iled w Hygier ther th	Co	17. Father's Name (First, Middle, L.	acti	5+		Secr	etar	7	18 Mothe	r'e Name	(First, Middle	Lav		name l		
and	d be d ental h ked of	To Be	Norman Bapst	1517								mith	, ,,,,,,,,,,		,aino,		
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or thame 23a or 28a-f show any injury or other traumatic event, the Marical Examinating mant be notified at ADGE.	-	19a. Informant's Name/Relationshi	p (Type, Print)			19b. Mailir	ng Addres	s (Street			l Route Numb	er, City	or To	wn, State, Zij	c Code)	
	and 2 saith a n 27 is		Ted Knight (sor	)								ter, M	ary]	Lan	d 2103	7	
Baltimore,	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition  XXBurial 2 □ Cremation	3 □Removal fr	om State	20b. P	lace of Dispo emetery, crer	sition (Na natory or	me of other plac	(e) F	eb.	10.	20c. l	ocatio	on - City or T	own, State	
	it. Pa rtmen rtant: njury		4 Donation 5 Other (Sp.			La	keside				200		Han	ıbuı	rg, Ne	w Yor	k C
Ba	Depa Impo any I		21. Signature of Cultural partice D	9	MOO	982	100					110,					
			23a. Part1. Enter the disease, or co shock, or heart failure. List o	omolications th	at caused	the deatl								•		Approxim- Interval B	ate
F	Physician		Immediate Cause (Final disease or condition	., 5.1.5 52.055	Br	casl	Ch	ncer								Onset and	d Death
	/Medical Examiner		resulting in death)	Due Due	to (or as a	conseq										3	
	Examiner	<u></u>	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying	b. — Due	to (or as a	LCCCRRCC	uerce off:										
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		10 (0. 40 0		301.00 017										
oʻ	te be executed ysician and e burial-transit	Exa	resulting in death) Last	c Due	to (or as a	conseq	uence of):										
8760,	# × #	licai	1	d													
x 68	ding pl	/Mec	IF FEMALE:	23c. If yes,	outcome	of pregna	1001										
Bo	atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐Li	ve birth	2 Feta	Ideath 3	Ectopic p					Ì		Date of deliv Month	ery Day	Year
Ö.	t the c by the tachec	hysi	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□∪	nknown			•	- 1								
Records, P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	ed by Physician/Med	Part II. Other significant condition	s contributing t	to death bu	t not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did		use co	ontribute to t	he cause of bably 4	
000	aw requir ts been si 2 should	piet										24a. Was		24	b. Were auto	opsy finding empletion of	s available
Œ Œ	tending Physician: The lavaleath. tor: After this certificate has the funeral director, page 2	Completed										perfe	rmed?	0	death?	2⊠ No	cause or
Vita Vita	Attending Physician: or death. ector: After this certifice by the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:			_		OA Othe	25		(Check only				1	J
ō	Phys r this sral di	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. D	Inpatier ate of Injur	y	ER/Outpatier 28b. Time of		28c. Injury	at at		ne 5 Res				m hosp	na
o	ath. r: Afte	atior	Natural 5 Pending 2 Accident investiga		Month, Day	Year)	Injury	м	Worl	k? Yes 2 ☐ f				,			
Division of Vital	al or Attendated after death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. P	lace of Inju uilding, etc	ry - At ho	ome, farm, str	eet, facto	y, office	_	1	28f. Location ( City or To	Street a	nd Nu te)	mber or Run	al Route Nu	mber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying 2 Medical E	Physician: To xaminer: On th and n	the best of ne basis of nanner sta	examına	tion and/or in	vestigatio	n, in my op	oinion, deal	th occurre	ed at the time,	cause(s	s) and nd plac	manner as s ce, and due t	tated. o the cause	(s)
	To th within To th	Me	29b. Signature and title of certifier	-> ;				29	c. License	number			29d. Da	ate sig	ned (Month,	Day, Year)	
)				- 10he	e M	W.			000	164	379		o	47	107		
	10		30. Name and address of person w	ho completed of Phus M		ath (Item	Bestar	Print)	2 5	de 30	o A	ngolu	MD	2	401		
í	Sta Registi		31. Date filed (Month, Day, Year)	2 200/3	2. Registra	r's Signa	iture	bod	e			9					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Mildred Florence White Bowden 200 Eb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Niconico Medical 50/13bull PENINSUA REGIONAL CenTU Date of Birth (Month, Day, Year) 3/2/1913 9. Birthplace (State or Foreign Country) Delaware 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Days 1 □ M 2 🗙 93 214-34-7992 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or Items 23a or 28a-f show dieal Examiner must be notified at Director 1 □Yes 2 TXNo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 9288 Hickory Mill Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married white Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð 3 XWidowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important; If them 27 is marked other the any Injury or other traumatic constitutions. 中 Bookkeeper Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George William Elliott Laura Clarence Maddox 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1016 Huron Court, Salisbury, MD 21804 Eunice Hayward/daughter Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Wicomico Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/13/07 Salisbury, MD 4 Donation 5 Dother (Specify) Park nature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** THEROSCLEPSTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months Month Year 4☐Pregnant at time of death 1 ☐ Yes 5 ☐ Other (specify) 2 No P.O. ed by the a detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been ( 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has death? 1 ☐ Yes 1 Yes 2 No 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral ( 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. • To the Funeral Director: After the completely filled in by the funera Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

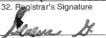
DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, FEB 1

29b. Signature and title of certifie

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-01055 State of Maryland / Department of Health and Mental Hygiene Timothy Francis Cotton 2007 06094 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1945 hrs Timothy Francis Cotton **Medical Examiner** February 6, 2007 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreign Washington Country) DC Days Hours Min. Months 220-72-1462 Director April 1,1959 1 XM 2 F Yrs 47 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location any 1 Yes 2 X No show s 23a or 28a-f shove e notified at once. Bethesda permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified</u> at once MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20814 9817 Parkwood Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 X No Yes Specify Yes 2 X No specify: White 3 Widowed Divorced If Yes. Give Year ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Advertising Telemarketing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemary Miller Be Paul Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Baltimore, MD 9817 Parkwood Drive, Bethesda, MD 20814 Patricia Cotton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) February 10, 2007 1 X Burial 2 Cremation 3 Removal from Stat Gate of Heaven Silver Spring, MD 4 Donation 5 Other Specify 21. Signature of Funeral Ser 22. Name and Address of Facility DeVol Funeral Home, RAG Gaithersburg, MD Park Drive, Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Modital Death a Complications of Head Injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit hysician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ᄑ 1 Yes 2 No 3 Probably 4 Unknown þ Completed Vital Records, 24b. Were autopsy findings available 24a. Was an certificate has been sector, page 2 should prior to completion of cause of autopsy death? performed' 2 No ✓ Yes Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) Jun 8, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ŏ 27. Manner of Death Operator of moped struck by motor vehicle Certification 2112 hrs 1 Natural 1 Yes 2 V No Division Pending filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after or To the Funeral Direct 3 Suicide Could not be or Town, State)
Cannon Avenue and East Franklin Street, Hagerstown, determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month Bay) 2007

29b. Signature and title of certifier

and manner stated

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 8, 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Eustaquia G. Cintron /Medical February 2007 2:08 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20423 Alderleaf Terrace Germantown Montgomery 8. Date of Birth (Month, Day, Year Sent. 21, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1 □ M 2 X F 230-76-9163 85 Director 1921 Puerto Rico Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at Montgomery 1 X Yes 2 □ No Director Germantown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20423 Alderleaf Terrace 20874 United States Funeral 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican Specify: White Completed by 3X Widowed 4 □ Divorced Year or Dates: "natural" al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 5 Own Home s 1 and 2 should be filed of thealth and Mental Hygie item 27 is marked other other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unavailable Maria A. Gonzales 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: if item 27 is i
any Injury or other trausonce. Carmen I Sadler / Daughter 20423 Alderleaf Terrace, Germantown, MD 20874 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Februar Arlington National 27, 2007 4 ☐ Donation 5 ☐ Other (Specify) Arlington , Virgina 21. Signature of Euneral Service Acenses 22. Name and Address of Facility 2. Name and Address of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 leaa. WU. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** Brain Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1☐ Yes 2X No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 X No 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation (Month, Day Year) 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No death 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D0061645 February 8, 2007 wend 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Génevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850 31. Date filed (Month, Day, Year) gistrar's Signature State FEB 1 2 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** LOUISE CROWE CHARLOTTE 10:00 A /Medical FEBRUARY 10 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 M 2 N F 82 Director 218-16-3439 09/29/1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show or Items 23a or 28a-f shov aminer must be notified at Allegany 11∏Yes 2 No Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 418 Warwick Avenue USA 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced "natural", Year or Dates: White of Health and Mental Hygiene.
Item 27 Is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Franklin Helbert Helen Marie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Warwick Avenue, Cumberland, MD Lloyd C. Crowe / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cemetery 02/16/2007 4 Donation 5 Dother (Specify) Rockville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HYPOTENSION DAYS resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS DAYS Sequentially list conditions, if any, leading to immediate caus. Enter Uncerty of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the bunial-trar Due to (or as a consequence of): P.O. Box 68760, physiciar Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No PANCYTOPENTA Completed CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s autopsy performe 2 **X** No or Attending Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mapher of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY /O, 2007 D54411

Registrar DHMH 17 Rev 1/2001 500 MEMORIAL AVE., SUITE 105, CUMBERLAND, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2007

32. Registrar's Signature

BEVERLY CALKINS,

FEB 1

31. Date filed (Month, Day, Year)

			For	State of M							1			000	0.7
		•	State Registrar			Cei	rtificate	of C	Peath		Re	g. No.	UUI	UbU	91
*	Physici	an.	1. Decedent's Name (First, Middle, La								<ol><li>Date of Deat Month</li></ol>	h Day	Year	3. Time of	
	/Medic		Lillian	J.				ffey			Februar	_	, 2007		М
	Examin	er	4a. Facility Name (If not institution, give		)		4b. City, T			of Death		-	County of Dea		
			WMHS-Braddock  5. Social Security Number 6.5	-	no (In vre	last birthday)	If Under	nber.	If Under 2	24 Hrs.	8. Date of Birth		Allega	rthplace (State of	or Foreign
	Funeral Director				76	Yrs.		Days	Hours	Min.	(Month, Day, 09 / 05 / 1		C	st Virgi	_
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Maryland Examinar court to notified at	0	MD Alleg	any			berla	nd						1 ⊠Yes	
	288-	Director	10e. Street and Number	<u> </u>	1		10f. Zip (	Code			11	0g. Citiz	en of What C	Country?	-
	3a or		532 N. Mechai	nic Street				2	21502				USA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spec	ofy Yes or No- lican, etc.)	1	4. Race - Am Black, Wh	nerican Indian,	
9	after or its	T.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐			1 ☐ Yes 2		Specify:	i, rueito ii	icall, etc.,		Specify:		
8	ural',	d by	3   Widowed 4 □ Divorced	Year or Dates:										White	
7	"nati	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual kind of work DO NOT us	l Occupa k done di e retired)	tion uring most	t of workin	g	16b. Kin	d of Busines:	s/industry	
12	within	m c	Elementary/Secondary (0-12)	College (1-4or	5+)		lomema					Н	ome		
9	Hygie other	BeC	17. Father's Name (First, Middle, Last	)	· · · ·	-	-0		18. Mothe	er's Name	(First, Middle, M				
lan	should be find Mental I	To B	Albert		Ph	illips	3		Haz	el	Ver	n	P	rice	
lary	de de de		19a. Informant's Name/Relationship				-				Route Number,	-			. 0
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 ie marke any injury or other traumatic once.		Jamie C. Blough  20a. Method of Disposition	/ daugnte		1 ろうし Place of Dispo			aver	-				ID 2150 or Town, State	2
nor	ages int of l t: If it	1	1 ₺ Burial 2 □ Cremation 3		,   0	emetery, crer	matory or oti	her place	.	02/16					ما
Ē	artme ortan injuri		4 Donation 5 Other (Special Signature of Survice Lice		nes									Marylan Home,	
Ba	Depa Impo any ir		14140	101	١						Cumber	-		21502	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	the death	h. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arre	est,		Approximat Interval Bet	e ween
F	Physician		Immediate Cause (Final disease or condition			. Heart	Foil	1100						Onset and	Death
42	/Medical Examiner		resulting in death)	Due to (or as			1011	ure					· ···		
	Examiner		Sequentially list conditions,	D		leart I	Diseas	e							
	pe sis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hyper											
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	ifficate g phy as the			U								-			
Вох	h cert endin use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pre	annancv				2:	3d. Date of de	-	
O. B	at the deat by the att tached for	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown			Other (spe						Month	Day '	Year
P.0	that thed by the detack	Phy	Part II. Other significant conditions	contributing to death I	hut not ree	ulting in the u	ndorhina ca	nico anto	n in Part I		23e Did tob	acco us	e contribute	to the cause of o	teath?
Records,	98	d by	Metastatic Brea			uniting in the u								Probably 4 🖂	
ec0	e law require has been si je 2 should b	Completed	Acute or Chron	ic Renal F	ailu	re					24a. Was a			autopsy findings completion of c	
_	ate pag	Con	Hyperkalemia								perform	ned?	death?	s 2□No	
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Linea itali				100		of Death	(Check only on	ө)			
of	Phys this al dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatier			4 🗆 140		e 5 Reside			ecify)	
L C	Jing I	lon	1 Natural 5 ☐ Pending	(Month, Da	ay Year)	28b. Time o Injury	M 28	Bc. Injury Work	ai ? ′es 2 ⊡i		8d. Describe ho	w injury	occurred		
Division of	Attending Physicien: r death. sctor: After this certific by the funeral director,	fica	3 Suicide 6 Could not I	28e. Place of in	njury - At h	ome, farm, str							Number or F	Rural Route Num	iber,
.=	- 0 = -	Certification:	4 Homicide	building, e	itc. (Specif	y)					City or Town	, State)			
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying P	hysicien: To the best miner: On the basis of	ot examina	wledge, deat	h occurred a vestigation,	at the time	e, date an inion, dea	nd place, a	nd due to the ca	use(s) a ate and	and manner a	as stated. ue to the cause(s	i)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner s			29c.	. License	number		2	9d. Date	signed (Mor	nth, Day, Year)	
	3		3///		4	/_		D13	3601			Fe	bruary	13, 20	07
	nas		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Victor Felipa, M.D., 925 Bishop Walsh Drive, Cumberland, MD 21502												
**	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 5 2007	32. Regist	rar's Signa	ature Acces	10								

			For Amend it	em 23ateperM	11. da	<b>P90</b> 2	2/28/0 rtificate	<b>7th</b> e of L	ealth a Death	and M	lental Hy	giene) ()	07	06099
			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Lawrence	Daniel	Cha	mbei	rs				Feb 15	, 2007	1 oai	1:15pm м
	Examir		4a. Facility Name (If not institution				,		Location o	f Death			y of Death	
			Beverly Living C					berla				Allega		
	Funeral Director		5. Social Security Number 217-10-1724 Usual Residence of Decedent	4014 005	e (In yrs. last )3	Vrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Par Aug 10	, 1913	9. Birth Cou	place (State or Foreign
	land ow		10a. State 10b. County		10c. City, To	own or Lo	ocation		-					10d. Inside City Limits
	Many Hear	to	MD Alleg	any		Cumb	perlan	d						1x□Yes 2□No
	r 28e	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	h wit	D B	512 Winifred Ro	ad				2	1502			U:	SA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	- 14. Ra	ce - Ameri ick, White,	can Indian,
9	after or ite	正	1X Never Married 2 ☐ Marri			1	1 ☐ Yes		Specify:	, r dorto	r ricari, cic.,			
00	72 hours after death with the Maryland natural; or iteme 23a or 28e-f ehow iteal Exambrar must be motified at	d by	3 Widowed 4 Divorced	Year or Dates:									<sup>fy:</sup> whit	
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12	filed within Hygiene. other than "	Ę.	Elementary/Secondary (0-12)	College (1-4or 5	5+)		nploye					handym	an	
9	filed Hygir other		17. Father's Name (First, Middle, I	Last)		,II-CII	пріоус	<i>,</i> u	18. Mothe	r's Name	(First, Middle,			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If them 27 is marked other than "natural, or tieme 23a or 28e-1 ehow important: if them 27 is marked other than "natural, or there is not any injury or other traumatic event, the Medical Examinar must be notified at an ance.	To Be	John Thomas								t Helen			
	1 and 2 sh Health and em 27 is rr ither traum		19a. Informant's Name/Relationsh Rose Ringer	<sub>пір (Турв, Print)</sub> niece		P.O.	Box 13	(Street a	nd Numbe	r or Rura	Corrig	ar, City or Town Janville		2 Code) 2 2 1 5 2 4
ore	of He of He fiter		20a. Method of Disposition  1  Burial 2  Cremation	2 Demoval from State	20b. Place ceme	of Dispo	osition (Nan	ne of ther place	9)		ate	20c. Location	- City or T	own, State
Ē	Pages ment of I ant: if its		' 4 ☐ Donation 5 ☐ Other (Sp	pecify)	Scarpe	elli Fu	neral H	lome,	P.A.	- 2	2/16/2007	Cresar	otown	MD
Baltimore,	*4 Donation 5 Other (Specify)  Scarpelli Funeral Home, P.A.  22. Name and Address of Facility Scarpelli Funeral H 108 Virginia Avenue										land MD	21502		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. D	o not ent								Approximate Interval Between
	Pnysician		Immediate Cause (Final disease of condition Reyal Mulus										Onset and Death	
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	The law requires that the death certific ite has been signed by the attending pi tage 2 should be detached for use as in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23d Da	ate of deliv	env
Вох	death atter	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pro						onth	Day Year
0	at the de by the a stached i	nysi	9 Unknown	9□ Unknown										
ď.	res that igned to be det		Part II. Other significant conditio	ns contributing to death b	ut not resultin	g in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use con	tribute to t	he cause of death?
rg	w require been sig should b	ed t		Eganic l	race	Syr	din	,ue	,		1 🗆 Y	es 2× o	3 🗌 Prot	bably 4 Unknown
Records,	s bee	Completed by		U		0					24a. Was		Were auto	ppsy findings available
R	The lay	E O									autop perfor	med?	prior to co death? 1  Yes	mpletion of cause of
Vital		0	25. Was case referred to medical						26. Place	of Death	(Check only of		1 🗀 192	2   110
\ \		To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatie	ent 2 ER/	Outpatier	nt 3 DO	A Othe			me 5 ☐ Resid		ner (Specif	(v)
υ of	ding Ph h. After th funeral		27. Manner of eath  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28t	. Time of	f 2	8c. Injury Work	at		28d. Describe h			
Ö	Attending r death. ector: After by the fune.	atic	2 ☐ Accident investig	ation	, , , , ,	,,	М		es 2□1	No				
Division	or Attendate death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of Inj	ury - At home, c. (Specify)	farm, str	reet, factory	, office		1	28f. Location (S City or Tow	itreet and Numi	ber or Rura	al Route Number,
	itei or A rs after ral Direc led in by	Cer												
	To the Hoepitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best Examiner: On the basis o and manner sta	f examination	ige, deatl and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the dead at the time, of	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	21			29c	. License	number		2	29d. Date signe	d (Month,	Day, Year)
	_		> Pekist	eller 1	717		U	10 8	1481		-	telma	my /	5,2007
			30. Name and address of person v	who completed cause of d	leath (Item 23		Print)	10.04	۲,	1	. ( /	1 00.	00. 1	112100
	- C4-	10	31. Date filed (Month, Day, Year)	A Ragietr	ar's Signature		UV I	<u>51</u>	un	U	my a	imoel	wa	rula 4000
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			1 - State Registrar		f Marylan	d / Depa		t of H	ealth a	and M	lental Hy		2007	06	100
	Dhysisi		1. Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Year	3. Time o	of Death
	Physicia /Medic		William Vince								02	07	2007	0010	A M
>	Examin	er	4a. Facility Name (If not institution, g			L C+	1		Location	of Death		-	County of Deal		
			WMHS's Frostburg 5. Social Security Number 6		7. Age (In yrs.		If Under	ostb 1 Year	urg If Under	24 Hrs.	8. Date of Bir		llegan	y tholace (State	or Foreign
	Funeral Director		218-16-4429	1 M 2 □ F	85	Yrs.	Months	Days	Hours	Min.	10 / 15 /	y, Year)		thplace (State buntry) cyland	or roraign
	2		Usual Residence of Decedent		10.00							1721	1161		
	ehov	2	10a. State 10b. County  MD Alleg		Tue. Cit	y, Town or Lo	nberla	and						10d. Inside (	Sity Limits s 2 □ No
	the N	Director	10e. Street and Number	gany		- Cui	10f. Zip					10a Citiza	en of What Co		
	within 72 hours after death with the Maryland ene. then "returel", or Iteme 23a or 28e-f ehow he Medical Examiner must be notified at		431 William	s Street	,				2 <b>1</b> 502	)			USA	,	
	death	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	.S. 13.	Was Deced	ient of Hi	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14	4. Race - Ame		·-
92	or its	y Fu	1 Never Married 2 Married	1 ∏ Yes If Yes, Giv	2 No /e LILIT 1		1 ☐ Yes				riicari, etc.,		Black, Whit Specify:		
Ş	ture!	ed by	3 Widowed 4 □ Divorced  15. Decedent's	Year or Da	ates: WW 1		dent's Usua						d of Business	White	
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<u>ya</u>		٩	William	Alexan	nder	Daw		of the state of th		sula				pbell	
Maryland 21215-0036	2 4 4 4	į š	19a. Informant's Name/Relationship  Judith Boling /								a <i>l R</i> oute Numb exingtor				
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition		20b. F	Place of Disponentery, cre					Date		ation - City or	Town, State	
Baltimore,	Page ent o ht: If ry or		1 Durial 2 Cremation 3 4 Donation 5 Other (Spe		State				1	12/00	/2007	Cumb	erland	MD	
a	permit. P Departm Importal any injui		21. Signature of Funeral Service Lie	ensee	Dui	2	2. Name an	d Addres	ss of Facili	y Ada	ms Fam:	ily F	uneral	Home,	F.A.
<u>m</u>	89 = 5 8		Kahur C.	Celanie	/		404 D	ecat	ur St	reet	, Cumbe	erlan	d, MD	21502	
760,	Physician and // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a conseq	ute uence of): ute uence of):	Ca	stv ve	bre	e l'	Thyn	nbo:	ŝi,	Interval Be Onset and	
P.O. Box 68	Attending Physician: The law requires that the death certifical rideath.  • ctor: After this certificete has been signed by the attending phy the funeral director, page 2 should be detached for use as the by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1☐Live b	tcome of pregna pirth 2 ☐ Feta nant at time of d	death 3	□Ectopic pr □ Other (sp		,			23	3d. Date of del Month	livery Day	Year
	w requires that been signed b should be deta	by Pt	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	inderlying c	ause give	en in Part I		23e. Did t	obacco us	e contribute to	the cause of	death?
Division of Vital Records,	equire	ted	Serzine	s, q	cuti	on	Ch	vo	mc		10	Yes 2□	No 3⊟Pi	robably 4	Unknown
င် မင်	has be	Completed	Kenal 7	outer	e	Obs	truc	tiv	e_		24a. Was	osv	24b. Were au	utopsy findings completion of	s available cause of
<u>~</u>	cete t	S	Unopo	thy							1 Tes	rmed? 2 XNo	death?	2 □ No	
<u>₹</u>	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	4.1.0		Check only				
ō	Phys r this sral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie		Bc. Injun	4 X Ni	ursing Ho	me 5 ☐ Resi 28d. Describe			cify)	
<u>o</u>	nding I ath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Injury	М	Worl	k? Yes 2∐	No					
<u>Nis</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At he	ome, farm, st	reet, factory	, office		F	28f. Location ( City or To	Street and	Number or Ri	ural Route Nu	mber,
	Hospital or Attenc 24 hours after death Funerel Director: tely filled in by the			1											1
	Hoep 24 hou Fune Hely fi	edical	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the	best of my kno asis of examina ner stated.	owledge, deal ation and/or in	th occurred evestigation	at the tin , in my o	ne, date ar pi <b>n</b> ion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause	(s)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and man	nor stated.		290	. License	e number			29d. Date	signed (Mont	h, Day, Year)	
	2/		<b>&gt;</b>	) ( Jan	ollin	MS	)	71	44	64		2	17/	200	7
no	2/10H		30. Name and address of person w	no completed caus	se of death (Iter	n 23a) (Type,	Print)	<u> </u>	. ( ′				1	/	
سا	7160		Sikander	L. Sandh			Tarn	Ter	race	, Fr	ostburg	, MD	21532		
	Sta Registi		31. Date filed (Month, Day, Year)	007	tegistrar's Signa	ture Age	College !								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lola Margaret Davis February 10, 2007 7:05 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12822 Davistown Road Allegany Frostburg If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🔀 F Yrs 215-42-4885 64 Director Maryland November 14, 1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Allegany Frostburg the 10e. Street and Number 12822 Davistown Road 10f. Zip Code 10g. Citizen of What Country? ō items 23a 21532-U.S.A Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ■ Never Married 2 Married Specify: White ō 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Librarian County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be a Llovd Davis Mary Chapman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Charlotte Bert Sister 2516 Butler Drive Norman Oklahoma 73069 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State February 12, 2007 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility open Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CANCER METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No spital or Attending Physicien: The lours after death.
ners! Director: After this certilicate It filled in by the funeral director, pagi 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1. Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funersh D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

12

Baltimore, Maryland 21215-0036

Box 68760.

Records, P.O.

Division of Vital

State Registrar

<u>QAMAR U. ZAMAN MD</u> 31. Date filed (Month, Day, Year)

of certifier

29b. Signature and ti

D0023371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

625 KENT AVENUE CUMBERLAND, MD 21502

32. Registrar's Signature

3 2007 FEB

		FOI		epartment of Health and I	Mental Hygien	ie		
		1 - State Registrar	(	Certificate of Death	Reg. N			
Physic /Med		1. Decedent's Name (First, Middle, Last)  ON Eld A Len	JA EVAN.	S	2. Date of Death Month	Day 2007 1628 M		
Exami		4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Death	1 4	c. County of Death		
····		COastal HOSP				vicomico		
Funeral Director	1	227-28-0121	M 2DF 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)  VA		
land ow t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits		
Maryl f sho	ţō	Md Wiconi	co Salis	bury		1 Yes 2 No		
death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number	-1	10f. Zip Code	10g. C	Citizen of What Country?		
ath wi	la l	401 Gateway	Street	21801		U.J.A.		
er dek Items ner m	ine	11. Marital Status / 1 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl</li> </ol>	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.		
-UU36 hours after tural"; or Ite	by F	3 N Widowed 4 □ Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Rlack		
72 hor	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. D	Decedent's Usual Occupation Give kind of work done during most of work	rkina 16b.	Kind of Business/Industry		
within iene.	app.	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of work ife. DO NOT use retired)	1.71	[./		
e filed wall Hygiel other the		17. Father's Name (First, Middle, Last)	11-00	1UCTION WOFKE	ne (First, Middle, Maide	INNINGTACTORY		
- O - O 0	To Be	Horace W	lest	Lillia	Badae			
Maryia d 2 should I th and Men ?7 Is marke traumatic	-	19a. Informant's Name/Relationship (Typ	e. Print) 19b. I	Mailing Address (Street and Number or Ru	ural Route Number, City	or Town, State, Zip Code)		
e, M 1 and 3 Health em 27 other tr		Shirley Gunter	- (daughter 16	Sy Sherwood Au		-ore md, 21234		
MOFe, Pages 1 and of Hezent: If Item		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	emoval from State cemetery	crematory or other place)		Location - City or Town, State		
		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		1 22. Name and Address of Facility Be	9-07 Hu	rlock, Md.		
balt permit. Departi Import any Inj		Mocilla	Kounds			Lity, Md, 2/85/		
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the death. Do not be cause on each line.	t enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between		
Physician	_	Immediate Cause (Final disease or condition	CEREBRON	IASCULTR AC	CIDEX	Onset and Death		
/Medical Examiner		resulting in death)	Due to (or as a consequence of	OF REAM	DICELL	25		
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of		1 Here	312		
cuted nd ransit	Examin	that initiated events						
oate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	):				
cate be e	dical	<b>V</b> d.						
		IF FEMALE: 23b. Was decedent pregnant 23	Sc. If yes, outcome pf pregnancy	_		23d. Date of delivery		
death certif death certif e attending ed for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year		
at the	hys	9 ☐ Unknown	9□Unknown					
COTGS, P.O. BOX to requires that the death certifue been signed by the attending should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.		ouse contribute to the cause of death?  No 3 □ Probably 4 □ Unknown		
ecord faw requir as been si 2 should I	Completed	1500F62	TENS10 25		24a. Was an	24b. Were autopsy findings available		
ge h age	dmo		. ,,,,,,,		autopsy performed? 1∐ Yes 2 <b>\</b> 2/1	prior to completion of cause of death?		
VITAI siclan: certificat irector, p	Be C	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	10 10 10 10 10 10 10 10 10 10 10 10 10 1		
ا کے اقات	TO E	examiner? 1 ☐ Yes 2 No			lome 5 ☐ Residence	6 □Other (Specify)		
on or oding Phys h After this funeral dir		27. Manner of Death  1 Vatural 5 Pending 2 Accident investigation	28a. Sate of Injury (Month, Day Year) 28b. Tin	me of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred		
DIVISION  or Attending after death. Director: Afte	ficat	3 Suicide 6 Could not be	28e. Place of injury - At home, farm building, etc. (Specify)			and Number or Rural Route Number,		
Safter al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, Sta	are)		
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (	29a. Certifier (Check only one) Certifying Phys	Ician: To the best of my knowledge, per: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)		
<b>To th</b> w within <b>To th</b> w сотр	Me	29b. Signature and title of certifier		29c, License number	29d. E	Date signed (Month, Day, Year)		
		/here	O Suace	D14256	3	2110/07		
BAZ		30. Name and address of person who co	mpleted cause of death (Item 23a) (T		425/1CE	AT THE CAPE		
	tota	31. Date filed (Month, Day, Year)	32. Redstrar's Signature	SAUSBURY	M/2	1801		
S Regis	tate trar		007 Seem &	Sparle		_		

			_ col	partment of Health and Meartificate of Death		ene a.w.2007 06103			
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death			
	Physici /Medic		Evelyn Mary Eichhorn		February	9 2007 5:25 PM			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
	i.		Anne Arundel Medical Center	Annapolis	Anne Arundel				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Davs Hours Min.	8. Date of Birth (Month, Day, )	9. Birthplace (State or Foreign Country)			
1	Director		327-26-4752 To A 200 P		09/15/19	34 Illinois			
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits			
	Mary -f eh	to	Maryland Anne Arundel Annapolis	2		1 Tyes 2 No			
	r 28e	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?			
	h with	o ie	940 Riversedge Circle	21401	U	nited States			
	deal	Funerai		. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	offy Yes or No-	14. Race - American Indian, Black, White, etc.			
98	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23a or 28e-f ehow he Mudical Exacilmer must be notified at	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	,,	2 4			
Ö	ural	d by	3 Widowed 4 □ Divorced Year or Dates:	1 1 1 1 1 2		willte			
5	n 72	Completed	· (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	9	6b. Kind of Business/Industry			
12	with iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+)	emaker		Home			
ğ	Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name					
lar	Ald be Al	TO B	William Foth	Mary Kijo	owski				
any	and has ma	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural	Route Number,	City or Town, State, Zip Code)			
Σ	and and n 27			aldridge Road, Anna		aryland 21401			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene.  Branchant: If Item 27 is marked other than "natural; or Iteme 23a or 28e-1 ehow eny injury or other traumatic event, in a Myclical Exaction must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State	position (Name of Damatory or other place)	ate 20	Oc. Location - City or Town, State			
Ë	Pagiment tant: jury o		4 Donation 5 Other (Specify) Kalas Ci	rematory 02/11	/2007 <u>E</u>	deewater, Maryland			
<u> </u>	permit Depar Impor Impor eny In			22. Name and Address of Facility George					
	40304	-		2973 Solomons Island					
100			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of cyling, such as cardiac or	respiratory arres	st, Approximate Interval Between Onset and Death			
	Pnysician /Medical		disease or condition aa.	icar vois	22 /120	snorpy Do			
	Examiner		Due to (or as a consequence of):			1.000			
	- 18	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Flooring			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.						
oʻ	e exe ien ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):						
8760,	The law requires thet the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical	d						
9	entific ding p	/Mec	IF FEMALE:						
Вох	eath certifii attending I for use as	Physician/Me	in the past 12 pontins?	□Ectopic pregnancy		23d. Date of delivery  Month Day Year			
o.	the de	ysic	1  Yes 2  No 9 Unknown	Other (specify)					
<u> </u>	thet the de led by the a detached f	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?			
rds	quires n sign ald be	d by			1 Yes	2 No 3 Probably 4 Unknown			
CO	s bee	oiete			24a. Was an	24b. Were autopsy finding available			
E	The It	Completed			autopsy performe	prior to completion of cause of death?  No 1 □ Yes 2 ☑ No			
ital	ian: rtifica	0	25. Was case referred to medical	26. Place of Death					
<u>_</u>	Physician: r this certifica ral director, p	To B	examiner?  1   Yes 2   No   Hospital: 1 Inpatient 2   ER/Outpatie	ent 3 DOA Other: 4 Nursing Hom	e 5 Residen	ce 6 ☐Other (Specify)			
0	ng Pt fter tt ineral	:uo	27. Many er of Death 1		8d. Describe how	r injury occurred			
Sio	ttendi death. stor: A	catio	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No					
Division of Vital Records,	l or Att after d Direct i in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Stre City or Town,	et and Number or Rural Route Number, State)			
	ospital hours a unerel i		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea		and all a second as a second				
	24 hos Eun Fun etely	edicai	(Check only one) 2 Medical Examinar: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date	e and place, and due to the cause(s)			
	To the Hospital or Attending Physician: The law requires within 24 Hours after death.  On the Funerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	₩e	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)			
}			On viselus	046462		11-Feb = 2007			
	6		30. Name and address of person who completed cause of death (Item 23a) (Type						
		4	Har Wels 781 23/200 MAM	~ ISI 167 "	Anny	110 MD 21401			
	Sta Registr		31. Date filed (Month, Pay Year) 32. Registrar's Signature	South 1	,				

FEMALE: 23b. Was decedent pregnant to the past 12 months?   23c. It yes, outcome of pregnancy   12b. Was decedent pregnant   12b. Was decedent pregnant at time of death   2   retail death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   24b. Was decedent pregnant at time of death   4   Pregnant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   24b. Was a pregnancy   25b. Date of prognancy   25b. Date of prog				1 - For State Registrar	State of Ma	arylan		artmen rtificate			and M		jiene	007	061	04
## Facility Newson of Individual Conference of Conference			_		- 1	99						Date of Dea Month	ith Day	y Year		
MONTCOMERY CRINERAL HOSP TTAL  State Redering on Groups 1 Size 1					.,,			4b. City,	Town, or	Location of		FEDRUAR				,
TO CONTROL OF THE PROPERTY OF				MONTGOMERY GENERA	L HOSPITA	L				OLN	EY				OMERY	
The State   Document   Total President   Total				1							Min.	8. Date of Birth (Month, Day	Year)		untry)	
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A   Constant   S   Content	999	urs after death		1 ☐ Never Married 2 🖾 Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give						gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Black, White	etc.	,
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A   Constant   S   Content	ָט ע	s 1 end I Heelt Item 2'		· · · · · · · · · · · · · · · · · · ·		20b. P	lace of Dispo	osition (Nan	ne of	1						
Physician // (active proposed part of the state of complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory areat.  Approximate Cause (Final disease or conditional	2	Peges nent of int: If I				1				1	EB 1	2, 2007	OLI	NEY, MAR	YLAND	
Physician // (active proposed part of the state of complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory areat.  Approximate Cause (Final disease or conditional	200	epertruborts nports ny inju		21. Signature of Funeral Service Licen	S <del>80</del>		2:	2. Name an	d Addres	s of Facilit	у					
Physician / Medical Examiner  Fremiling in death)  Fremiling in death but not resulting in the underlying cause given in Part I.  Fremiling in death but not generally in the underlying cause given in Part I.  Fremiling in death but not generally in the underlying cause given in Part I.  Fremiling in death but not generally in the underlying cause given in Part I.  Fremiling in death but not generally in the underlying cause given in Part I.  Fremiling in death but not generally in the underlying cause given		E = 50%		CHARTEN		4 45	19	091 R	OCKV.	ILLE	PIKE	, ROCKV	ILLI	E, MARYL		
Sequentially list conditions, any, leading to amordiate cause. Eliminated events in resulting in death Last included events in the past 12 morths?    FFEMALE:   FFEMALE:   Solvas accordent pregnant in time past 12 morths?   Solvas decedent pregnant at time of death Significant conditions contributing to death but not resulting in the underlying cause given in Part I.   1   Yes   2   No   3   Probably 4 & Onknown   28   Were autopy findings available prior to completion of cause of death?   1   Yes   2   No   3   Probably 4 & Onknown   28   Were autopy findings available prior to completion of cause of death?   1   Yes   2   No   3   Probably 4 & Onknown   28   No   28   N	ı			Immediate Cause (Final disease or condition	one cause on each II	ne.								DW	Interval Bet Onset and	tween Death
25. Was case referred to medical examiner?  1   Yes   2   No   28. Date of Injury at   28. Date of Inj	oo,	be executed icien end burial-transit		that initiated events	b. Due to (or as	a conseq	AT (Cuence of):			560	<b>100</b> 0	ONIE	7			
25. Was case referred to medical examiner?  1   Yes   2   No   28. Date of Injury at   28. Date of Inj	.O. DOX 0	the death certifi y the ettending Iched for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	I death 3								-	Year
26. Place of Death (Check only one)  27. Manner of Death   Townshigation   Tow	Ĺ	se that gned b		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	use contribute to	the cause of c	death?
25. Was case referred to medical examiner?  1   Yes   2   No   28. Date of Injury at   28. Date of Inj	5	require sen sig		DEMENTIA	, Co	ROI	VAR	4 A	21	FRI	+	1 🗆 Y	es 2	□No 3□Pro	bably 4 🖎	Unknown
25. Was case referred to medical examiner?  1	ם ב	The law ste hes b page 2 st	omple	DISFORE, I	TABET	ES	WE	Thi	tu.			autops	sy męd?	death?		available ause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  18111 PRINCE PHILLIP DRIVE, OLNEY, MARYLAND 20832  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	110	clan: ertifica ector,	0								of Death					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  18111 PRINCE PHILLIP DRIVE, OLNEY, MARYLAND 20832  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	5	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending		y Year)						28a. Describe ni	ow injur	y occurred		
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State 31. Date filed (Month, Day, Year) 37. Registrar's Signature		0		30. Name and address of person who	7 - ~	1/1			рит		יז ד קת	E OINE	V 1	MARVI AND	2083	2
					32 Registr			ALIVOE		TUTE	TYT A	L, ULINE	1 e 1	TINI DENIN	2003	

			For State Registrar	State of Ma	ryland		rtment of H		d Mental Hy		3 0 0 ==	A 4 1 6 7
			Registrar  1. Decedent's Name (First, Middle, Last	)		Cer	lilicale of L	Jeain	2. Date of De	Reg. No.	2007	3. Time of Death
Н	Physici	an							Month	Day		M
The same	/Medic Examir		RACHEL ANN  4a. Facility Name (If not institution, give	FRAZIEF	<u> </u>		4b. City, Town, or	Location of De	FEB.	4c.	2007 County of Dear	3:05A "
	100	er	Asbury Methodi	st Villa		a briedh da d		ersbu:	rq		MONTGO	MERY
	Funeral Director		5. Social Security Number 6. Se 117-38-9292	TM NEEE	(lñ yrs. las '6	Yrs.	Months Days		lin. (Month, Da	ay, Year)	Co	thplace (State or Foreign ountry)
C.,	and the second		Usual Residence of Decedent	/	0				Mar.	4,1	930 M	laryland
	yland now		10a. State 10b. County		10c. City, 7	Town or Loc	eation					10d. Inside City Limits
	a-f st	ctor	MD Montgo	mery			Gaither	sburg				1 XYes 2 No
	th the	Director	10e. Street and Number	-			10f. Zip Code			10g. Citi	zen of What Co	ountry?
	ath w		9 Chestnut S	treet, #	201		_	0877			U.S.	
	er dez	Funeral	TTT Marian Gladag	12. Was Decedent Ev Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pı	? (Specify Yes or No uerto Rican, etc.)	)-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
36	s afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	)	1	□Yes 2X No	Specify:			Specify: B	lack
9	within 72 hours after death with the Maryland ene. than "naturar", or items 23a or 28a-f show ha Medical Eximiner must be notified at		15. Decedent's Edu			16a. Deced	ent's Usual Occupa	ation		16b. Kir	nd of Business	Industry
15	nin 72 .r. .n. "ng Medic	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+		(Give I	kind of work done a OO NOT use retired,	urina most of	working			
212	d with giene er tha the I	E	12th	College (1-401 3+	,	Ca	re-give	r		P	rivate	
pu	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Extminer must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	, Maiden	Surname)	
ylaı	2 should be and Mental is marked or aumatic eve	인	Harry Posey					Es	sther Mi	les		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Ty		. 1	19b. Mailing	g Address (Street a	nd Number or	Rural Route Numb	er, City o	r Town, State, 2	Zip Code) 20879
	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		Joyce Conerly  20a. Method of Disposition	(Daugnte	r)	198	33 Brami	ole Bu	ısh Dr,	Gait	thersb	urg,MD
Baltimore,	Pages 1 an nent of Hea nnt: If Item 2 ury or other		1 Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cerr	netery, crem	atory or other place				cation - City or	
Ħ	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)  21. Ign 1 = 1 - uneral Service   ce   s	. /	Emo		rove Cer		L7/07	Gait	thersb	urg,MD OME, P.A.
Ba	permit. Pag Department Important: I any injury o		21. Ignitiae of Funeral Service (ice)	Mond	en	6.4	6 N. Was	shinat	On St R	CCK	KAL H	OME, P.A. MD 20850
15	0-		23a. Part1. Enter the disease, or compl	ications that caused the	he death.	-		_			, TTTE,	
1	Physician		shock, or heart failure. List only of Immediate Caus (Final	ne cause on each line	0 0 882					,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a			rdial In	nfarct	ion			minutes
	Examiner		On the Park of the								- 1	
	70 Æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequer	nce of):						
	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a								
8760,	be ex ician burial	E E		Due to (or as a	consequer	ice oi).						
687	icate physi s the I	dical		d								<u> </u>
	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pt						2	3d. Date of del	iven
Вох	death atter	ciar	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at ti			Ectopic pregnancy Other (specify)			-	Month	Day Year
o.	w requires that the de been signed by the should be detached	hysi	9 ☐ Unknown	9□Unknown					1.7			
S, D	ss tha gned l	y P	Part II. Other significant conditions con	ntributing to death but	not resultir	ng in the un	derlying cause give	n in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
ord	equire en si	pa	Pulmonary Em	bolism					_ 1 🗆	Yes 2	□No 3□Pr	obably 4 ⊠Unknown
Records,	2 2 3	Completed by	Venacava Filt	er, Hype	rten	sion			24a. Was		24b. Were au	topsy findings available completion of cause of
<u>=</u>		E	Esophagitis,	Anemia.	Thro	mbos	is of l	ea	perfo	rmed?	death? 1 ☐ Yes	
Vital	sician: Th certificate rector, pag	Be (	25. Was case referred to medical				1.	26. Place of [	Death Check onl	one		
or \	Physician: rthis certific ral director,	2	1 163 2 2 10	lospital: 1 ☐ Inpatient		R/Outpatient		4 LX Nursin	g Home 5 ☐ Resi			cify)
n C	IIng F After Unera	ii o	27. Manner of Death  ↑ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injury Work		28d. Describe	how injury	y occurred	
<u>isi</u>	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of injury	v - At home	e farm stre		′es 2∐No	28f Location /	Street and	1 Number or P	ıral Route Number,
Division or	after after Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of injury building, etc.	(Specify)	5, 141111, 6116	ot, raciory, omco		City or To	wn, State)	)	rai noute ivuniber,
	Hospital 24 hours a Funeral I		29a. Certifier 1 ** Certifying Physical Control of the Control of	sician: To the best of	my knowle	edge, death	occurred at the tim	e, date and pl	ace, and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Medical	(Check only 2 Medical Examl one)	ner: On the basis of e and manner state	xamination ed.	n and/or inv			occurred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature analtitle of certifier	1	10	.1.	29c. License				e signed (Monti	
	4		"IV Novevi	Bursa				4115		F	eb. 11	, 2007
			30. Name and address of person who co					7 7500	., Gaith	oral	hura M	D 20977
	Sta	to	H. Robert Birs	Registrar		e .		T WAG	·, Galti	TET 2	Dara'	D 2.0011
	Sta		FFR 1 3 2007		de	Mari	Al a					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		artment of F			_	0.00	06106
	267	- 11	Hegistrar     Decedent's Name (First, Middle, Last	·)		inicate or	Death	2. Date of De	Reg. No.	2001	3. Time of Death
	Physici /Medic		Ralph Williamson H	Fairbanks. Jr.				Februa	ry 6		10:04 A M
1	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of I			County of Death	1
			Anne Arundel Medic	cal Center		Annapol:			Aı	nne Arun	del
	Funeral		5. Social Security Number 6. Se	AM SOLE	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Min. (Month, Da	ay, Year)	Cour	lace (State or Foreign
,AT	Director		Usual Residence of Decedent	70	115.			Jan. 1	7, 19	937 Mass	achusetts
	/land ow		10a. State 10b. County	10c. City	Town or Lo	cation				1	0d. Inside City Limits
	a-f sh	햦	Maryland Anne Art	undel Anna	apolis	}					1 □ Yes 🏠 🕅 No
	or 28	Sire	10e. Street and Number			10f. Zip Code			_	en of What Cour	•
	23a ust b	ral	3159 Catrina Lane			214				ted Stat	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes AM No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2XX		n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
21215-0036	tural cal Ex	9	15. Decedent's Edu	ucation	16a. Deced	dent's Usual Occup	pation		16b. Kin	nd of Business/Inc	dustry
215	within 72 iene. • than "na the Medic	Completed	(Specify only highest grad	de completed)  College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retired	during most o d)	of working			,
21	filed withi Hygiene. Ither thar	E	Elementary, decordary (6 12)	4		Salesma:	n		Te.	lecommun	ications
p	be filed tal Hygid d other event, the	Be	17. Father's Name (First, Middle, Last)	7 . 1 . 1				Name (First, Middle		Sumame)	
yla	Men Men Marke Marke	ို	Ralph Williamson H		I			a Fitzgera			
	.1 and 2 should be fil Health and Mental H tem 27 is marked ott other traumatic even		19a. Informant's Name/Relationship (7) Mary E. Fairbanks	/ Wife	3159	Catrina	Lane	or Rural Route Numb Annapoli	er, City or .S,M	Town, State, Zip D 21403	(Code)
ore	Pages 1 nent of He nt: If iten		20a. Method of Disposition  1 □ Cremation 3 □ I			sition (Name of natory or other plac		Date	20c. Loc	cation - City or To	wn, State
Ë	nit. Pag artment ortant: Injury c		4☐Donation 5 ☐ Other (Specify,	St.		s Cemete				polis, M	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	see							1 Home,Inc., MD 21401
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	. Do not ent	er the mode of dyir	ng, such as ca	ardiac or respiratory a	ırrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	a. Myocar	dia	-IIN	fare	ction			Onset and Death
تكور	/Medical Examiner		resulting in death)	Due to or as a consequ	ence of):	, .		11	/ /		
		<u>~</u>	Sequentially list conditions,	b. Fige Hz	per ence of):	TEAS/T	2n, 1	tion Hyperch	roll	sterd	10 yrs
	uted J insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, ,	,			,			•
oʻ	be executed sician and burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	ence of):				-		
8760,	ate be hysicia the bu	ical	(	d							
9	ng ph	Med	IF FEMALE:		-						
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□	Ectopic pregnancy Other (specify)	у		2:	3d. Date of delive Month	ery Day Year
	res that signed by	by Pr	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t	tobacco us	se contribute to the	ne cause of death?
Vital Records,	w require been sig should b	ed b						1	Yes 2	No 3 □ Prob	ably 4 □Unknown
ဝ၁	law re is bee 2 sho	Completed						24a. Was		24b. Were auto	psy findings available
Ä		E						— auto perfo	psy ormed? 2 No	death?	inpletion of cause of 2 ☐ No
/ita	stcian: The certificate herector, page	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (Check only of			
or V	Physician: this certifical director,	ည	1 ☐ Yes 2 No	7	R/Outpatier		4 ∐ Nurs	ing Home 5 ☐ Resi	idence 6	□Other (Specif	y)
E	ding P. h. After t		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury	occurred	
isi	Attending r death. ector: After by the funer	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At hor	me farm etr		Yes 2 □ No		Ctroot one	Number or Rura	I Davida Alverta v
Division	I or Attendate after death Director:	Certification:	4 ☐ Homicide determined	building, etc. (Specify	)	eet, factory, office		City or To	wn, State)	i Number or Hura	r Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	/sician: To the best of my knov liner: On the basis of examinat and manner stated.	vledge, deat ion and/or in	h occurred at the til vestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and	and manner as si place, and due to	tated. o the cause(s)
	To the I	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
			- Kanan O	munto.	mi	017	110	CT.	215	100	
	(12)		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)			~	, , ,	
			SAM FRUMK	Lin mo.	62+	lings.	Hihw	AY N.	We	stport	CT06880
ft.	Sta		31. Date filed (Month, Day, Year)	2 2007	ure	Bear 10 1	J	/		V	
	Regist	αI	- 1 Ban 67 46	- LIVE PARTY	10	A					

		1 - For State Registrar	Otate of Marylar	•	tificate of De	eath	Reg. I	-2007	06109
Physi		1. Decedent's Name (First, Middle, Las Alfred Ken		gow, Sr	•			Day Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give		<u></u>	4b. City, Town, or Loc	cation of Death	bruany 1	4c. County of Death	1
KA,		Peninsula Regional 5. Social Security Number 6. Se	1.16.01	H	SAUSO if Under 1 Year   If		Data of Birth	Nicomies	
Funera Directo		220-32-9281	ex 7. Age (In yrs. 71 71	Yrs.		Hours Min	Date of Birth (Month, Day, Yea 0/14/193	9. Birth Cou 5 Ma	place (State or Foreign intry) ryland
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
e Many la-f sh tifled	ctor	Maryland Wicomi	.co F	ruitlar	nd				1 ∐Yes 2 █ <b>X</b> No
with the	Funeral Director	10e. Street and Number 800 Slab Bridge	Poad		10f. Zip Code 21826		10g. (	Citizen of What Cou USA	intry?
death ns 23	Jeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Specify	Yes or No-	14. Race - Ameri	
<b>BAITIMORE, IMARYIANG 21213-UU3D</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 🖪 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		**	Mexican, Puerto Hica Specify:	an, etc.)	Black, White	
13-U	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occupation kind of work done during OO NOT use retired)	on ing most of working	9	Kind of Business/Ir	ndustry
within than the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		er/electric			Glasgow Electric	
e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)		1		3. Mother's Name (Fin		,	
Yiand ould be file Mental Hy larked oth	10	Fred Hitch Glaso				Georgia Ev		<u>-</u>	
Mar d 2 sh tth and tth and traum		19a. Informant's Name/Relationship (7)  Joan Lewis Glasgo			g Address (Street and Slab Bridge				
item 2		20a. Method of Disposition	20b.		sition (Name of natory or other place)	Date		Location - City or T	
Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	rsons (	Cemetery	2/13/0	1	alisbury,	
Baltimore, permit. Pages 1 a Department of He Important: If item any Injury or othe	ouce.	Signature of Funeral Service Licen			Ionloway∘Fu 601 Snow Hi	dheral Hom ill Rd., S	e Profes Salisbur	ssional A y, MD 218	ssociation 04
		3a. Part1. Enter the disease, or compensor, or heart failure. List only	moson CFS policy income cause on each line		er the mode of dying, s	such as cardiac or re-	spiratory arrest,		Approximate Interval Between
Physicia		immediate Cause (Final disease or condition	a adenoca	1 Cino	ma obt	the Colo	mi	1	Onset and Death
/Medica Examine		resulting in death)	Due to (or as a consec						
	Je.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consec	quence of):		***			
scuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
b8/bU, rificate be executed g physician and as the bunal-transit	a EX	resulting in death) Last	Due to (or as a consec	quence of):					
<b>58 / 5U,</b> ificate be expression as the burial	ledical		d						
death cert death cert e attending d for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn 1□Live birth 2□Fet		Ectopic pregnancy			23d. Date of deliv	-
COTCS, P.O. BOX w requires that the death cer been signed by the attendin should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant et time of 9 Unknown		Other (specify)			Month	Day Year
ords, P.O. requires that the een signed by the nould be detache	by Ph	Part II. Other significant conditions	ontributing to death but not re-	sulting in the un	derlying cause given ir	in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
oras equires en sign							1 🖸 Yes	2 No 3 Pro	bably 4 Unknown
M M M	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
ate pag		OF Was assessed to seed in a					performed 1□ Yes 2☑1		2 No
	To Be	25. Was case referred to medical examiner?	Hospital: 1 1 Inpatient 2	] ER/Outpatien	Other	<ol> <li>Place of Death (Cl</li> <li>4 □ Nursing Home</li> </ol>		6 ∏Other (Spec	(6/)
- 0 0		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury at Work?		Describe how in		'''
Si tten Si tten tten tten tten tten tten tten tte	catic	2 Aocident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes	s 2 No	Landing (Ottoor		10 11
DIVISION PRIME OF Attenue of the prime of the control of the contr	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ify)	eet, factory, office	281.	City or Town, St	and Number or Rui ate)	ai Houte Number,
24 hos Fun	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time, restigation, in my opini	date and place, and ion, death occurred a	due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	mn		29c. License nu	umber	29d. [	Date signed (Month)	Day, Year)
Of the	)	30. Name and address of person who		m 23a) (Type. I	Print)	7 1 2 7			
100		Alon DAVIS	mp 1001	Power	St. Sc	alisbury	mo	21800	+
Regi	State	31. Date filed (Month, Day, Year) FEB 13 2	32. Registrar's Sign	ature					
DHMH 17 Rev		1 1 1 0 7	OUT Masures	D. A	AAS )				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Mary		artment of H		R	g. No.	06110
Physic /Med		1. Decedent's Name (First, Middle, Last	ng s				2. Date of Deat Month	Day Year	3. Time of Death 7 6, 30 A M
Exam		4a. Facility Name (If not institution, give	street and number)	Hospite/	4b. City, Town, o	r Location of Dea	th	4c. County of Dea	ath D
Funera Directo	_	109-09-9554	7. Age (In M 2 F 94	yrs. fast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) C	thplace (State or Foreign ountry) York
Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County	100	:. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the a or 28a-	Director	Maryland Howard  10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	•
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental hygiene. Importent: If Item 27 is marked other then "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Evantical must be notified at	by Funeral	7220C Edenbrook Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ive, Apt TI  12. Was Decedent Ever Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			.046 lispanic Origin? (San, Mexican, Puel Specify:	Specify Yes or No- nto Rican, etc.)	U.S.A 14. Race - Am Black, Whi Specify:	erican Indian,
21215-0036 solvithin 72 hours aft gione. or then "natural", or it the Medical Exercit.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	16b. Kind of Business	
land 2. Id be filed vental Hygie ked other it	To Be Co	17. Father's Name (First, Middle, Last)  Adolf Holzma	4		Civil Eng	18. Mother's Na	me (First, Middle, M	Privat Maiden Sumame)	e
Maryland nd 2 should be flie sith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (7)  Harold R. Holzman -	/pe, Print)			and Number or R	ural Route Number	, City or Town, State,	Zip Code)
Baltimore, Dermit. Peges 1 ar Depertment of Hea Importent: if Item Any Injury or othe		20a. Method of Disposition  1 XS Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	Ob. Place of Dispo cemetery, crei		се)	Date	20c. Location - City of	
Balti permit. Depertm Imports any Inju		21. Signature of Funeral Service Licens		22 H:	. Name and Addre	ss of Facility i Funeral	Home, Inc.		ryland_20904
Physiciar /Medica Examine		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	ne cause on each line.  a. Aute My		er the mode of dyir		c or respiratory arre		Approximate Interval Between Onset and Death
8760, sate be executed physicien and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cor  Due to (or as a cor  d.						
.O. Box 6 the deeth certific by the ettending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, out <i>co</i> me of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
Cords, P w requires thet s been signed b should be det		Part II. Other significant conditions co	ntributing to death but no		hock,	en in Part I.	_ 1	oacco use contribute to	o the cause of death? robably 4 Junknown
The law cete has by page 2 st	Completed by	Africal F.br. Next	(m) /4	cck h	le-ol	bulve	24a. Was a autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
Division of Vital Records, To the Hospital or Attending Physician: The law requires I within 24 hours effer death. To the Funeral Director: After this certificete has been signs completely filled in by the funeral director, page 2 should be	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1-Natural 5 Pending 2 Accident investigation	Hospital: 1-Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	28c, Injur Wor	er: 4 🗆 Nursing I		el nnce 6 ⊡Other (Spe w injury occurred	ecify)
Divis	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str pecify)	eet, factory, office		28t. Location (St. City or Town	reet and Number or P n, State)	ural Route Number,
Dit To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	one)	sician: To the best of my ner: On the basis of exa and manner stated.	r knowledge, deat mination and/or in	n occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
OF IK	)	29b. Signature and title of certifier	C	MI	29c. Licens	e number		Feb 10	
3(1)		30. Name a d address of person who o	ompleted cause of death					110	210-14
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 1 2 20	32 legistrar's S	Signature	out .	0.			·

		•	State of Mar State Registrer		artment of Health and rtificate of Death	Mental Hygie	L. O O I	06111
	Physici /Media	al	1. Decedent's Name (First, Middle, Last)  Clarence William Henge	st In.		2. Date of Death Month	Day Year 11 2007	3. Time of Death 0.610
	Examin	er	4a. Facility Name (If not institution, give street and number)  WMHS~Braddock Campus		4b. City, Town, or Location of Dea Cumberland		4c. County of Death Allegan	И
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 □ F  7. Age 1 M M 2 □ F  Usual Residence of Decedent	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Birthp Cour	place (State or Foreign
	Maryland f ehow	ior	The state of the s	10c. City, Town or Lo Hyndmai			1	10d. Inside City Limits 1   Yes 2 □ No
	sa or 28a	Funeral Director	10e. Street and Number 202 Clarence St.		10f. Zip Code 1 5 5 4 5	10g.	Citizen of What Cour	ntry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural; or iteme 23s or 28s-f show other traumatic event, Its Mudical Exaction must be notified at	à	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  1 Yes 2 No No If Yes, Give  Year or Dates:	rer in U.S. 13. V	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
21215-0	d within 72 ho piene. r then "natur tre Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give life. L	dent's Usual Occupation kind of work done during most of wi DO NOT use retired)	orking	b. Kind of Business/Inc.  Restaur	
Maryland 2	2 should be filed and Mental Hygis Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Clarence William Hengs:	t Sr.		Belva Bu	rkett	
altimore, Mar	0 0		19a. Informant's Name/Relationship (Type, Print)  Linda Raley/ Wife  20a. Method of Disposition  1 ♥ Burial 2 □ Cremation 3 ♥ Removal from State 4 □ Donation 5 □ Other (Specify)	PO 1	natory or other place)	Date 200	5 4 5 c. Location - City or To	own, State
Baltin	permit. Pag Department important: f eny injury o		21. Signature of Funeral Service Licensee	H	Cemetery 2. Name and Address of Facility Hoome, 169 Clare	ince St.	Hyndman	PA Funeral , PA 15545
*	Certificate be executed ding physician and fine es the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):  consequence of):  consequence of):	ic Shock Annythmia			Approximate Interval Between Onset and Death
P.O. Box 68	ne death certific the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Division of Vital Records, P.	aw requires as been sign 2 should be	Completed by Pt	Part II. Other significant conditions contributing to death but $51eep$ Aprila,	-	nderlying cause given in Part I.		2 No 3 Prob	
ital R	The sage	Ве Соп	25. Was case referred to medical examiner?			performed 1 ☐ Yes 2 X	No 1 ☐ Yes	2□ No
ion of V	ng Phys ter this neral di	은	1 Yes 2 No Hospital: 1 Inpatien  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  Hospital: 1 Inpatien  28a. Date of Injury (Month, Day)			Home 5 Residence 28d. Describe how		γ)
Divis	To the Hospitel or Attending Ph. within 24 hours after death. 7 To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, stri (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rura State)	l Route Number,
	the Hospi in 24 hour the Funer ipletely fill	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or inv	vestigation, in my opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
<b>7</b>	Tont	N	29b. Signature and title of certifier		29c. License number  00059157		- 1 3 - 2 0 0 7	Day, Year)
Q	6/3		30. Name and address of person who completed cause of deal Dr. Mashukur R. Khan 1	44 5th A	Print)			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Pegistrar FEB 1 4 2007	's Signature	and a			

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

State

Ghousia Sultana,

FEB 1 3 2007

31. Date filed (Month, Day,

M.D.

Registrar's Signature

12107 Heritage Park Cir, Silver Spring, MD

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Year **Physician** FEB. 2047 **EDWARD** 6, ROBERT HACKEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 24, 1949 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex M 2□F **Funeral** 57 Yrs Maryland 216-50-8974 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at annea. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Funeral Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2307 Darrow Street 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married XXMarried Baltimore. Maryland 21215-0036 1 ☐ Yes 200 No Specify Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) A&A Plumbing Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12th Supply Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Agnes Daye Raymond Edward Hackey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2307 Darrow St., Silver Spring, MD 20902 Valeria Hackey (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial / 2 □ Cremation 3 □ Removal from State 2/14/07 John Wesley Cem |Clarksburg, MD 4 □ Donetton 5 □ Other (Specify) 22. Name and Address of FaciliSNOWDEN FUNERAL HOME, P.A. 21. Signature Funeral Service 246 N. Washington St, Rockville, MD 20850 vige 23a. Part1. Enter the disease, or complications that caused the death. on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Lung Cancer yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏕 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate or Vital | 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation (Month, Day Year) 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my critical death according to the cause (s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

P 50 98 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

P NAWAZ, M.D. POBOX 83819 Gai Hersburg MD 20883

(Month, Day, Year)

FFR 1 3 2007 D

State Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :30.4M **Physician** OWAR GO. 000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDERUK MOTTER WENCRUIK HUE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 21 F Director FRESERVER Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifiled at 1 Nes 2 No FREDERIC FREDERICK Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number '.S., 2170 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Newer Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ № 0 Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) COOK 64 Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) OAK ( h FR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau GRICE Aut. Frico. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State PAIRVIEW CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARU ROLLINS FUNETAL HOAD 21. Signatur of Funeral Service Li Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes > No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? 1□ Yes 2☑ No After this certificate Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA မှ 1 Yes 1 | Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending i within 24 hours after death.

To the Funeral Director: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 **Physician** m 5:10/PM Februar "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner moll Westmins ZVV 181 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**▼** M 2 □ F Director 89 216-03-2983 <del>June 27 1917</del> PA 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 PYes 2 No Directo Carroll Taneytown MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ě ms 23a must b 100 Antrim Street 21787 USA Funeral death urai", or items 2 I Examiner mus Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the ath and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Leader Congoleum 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue Lowry Bertram Henry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warfieldsburg Rd Westminster, MD 21157 <u>Jane Bair/daughter</u> important: If item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/13/2007 1 Deurial 2 Cremation 3 Removal from State Deer Park Cemetery Smallwood, MD 4 Donation 5 Other (Specify) of Funeral Servi Pritts Funeral Home and Chapel, P.A. Washington Rd Westminster, MD21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonio Physician D3/2 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical SS attending | IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tyes 1\_Inpatient P 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After th 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 10005994 WIL 10+11/1

State Registrar 30. Name and address of erson who impleted cause of death (Item 23a) (Type, Print)

200

CARNO

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on 31. Date filed (Month, Day, Year) 295

SANEY

32. Registrar's Signature

		1	For State Registrer	e of Maryland / Depa Cer	artment of F			ene 007	06116
1	4		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
4	Physicia		Perry Darryl Hamilto	on				y 9,2007	12:48 P. M
,	/Medic Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, o	r Location of Death		4c. County of Death	_
Œ.	46		1100 Owens Road # 4		Oxon Hi			Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 218–86–1311	7. Age (In yrs. last birthday) F 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 1/30/63	'ear) Cou	place (State or Foreign intry) rerly, Md.
	pu 🖈	⊢	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	cation				10d. Inside City Limits
	aryla shov	. 1	Md. P.G.		n Hill				1 X Yes 2 □ No
	the M	Director	10e. Street and Number		10f. Zip Code		100	J. Citizen of What Cou	untry?
	with with the same		1100 Owens Road #	411		20745		U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f show important: If item 27 is marked other than "natural", or lieme 23s or 28s-f show any injury or other traumatic event. Ite Medical Exeminar must be notified at ance.	by Funeral	11. Marital Status  12. Was Arme 1 Never Married 2 Married 1   Yes	Decedent Ever in U.S. d. Forces?	Was Decedent of Hif Yes, specify Cubin	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	vithin 72 ho ne. han "natur n Medical	Completed		ge (1-4or 5+) (Give life.	DO NOT use retire	during most of work॥ d)	ng	sb. Kind of Business/ rivate Inc	·
7	lied v lygie ther t		12th 17. Father's Name (First, Middle, Last)	R	etail Sal	18. Mother's Name			uscry
anc	ad of	Be	Perry C. Hamilton				y T. Jac		
Ž	should nd Me mark mati	၉	19a. Informant's Name/Relationship (Type, Print,	19b. Maili	ng Address (Street	L		City or Town, State, Z	ip Code)
S S	nd 2 ;		Shirley T. Hamilton/M	other 2910	Brightse	eat Rd.,Gl	enarden,	Md. 20706	
Je,	s 1 au f Hea itam othe		20a. Method of Disposition	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)		oc. Location - City or	Town, State
E	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	Harmony	Mem. Par	k 2/24	1/07 I	andover, N	Maryland
Baltimore,	permit. Departra Importe any inju		21. Signature of Funeral Service Licensee	2. July 4	<sup>2</sup> Hamsand Addr 925 Burro	ington & oughs Ave.	Sons Co. ,N.E.,Wa	,Inc. shington,D	.C.20019
	* 3		23a. Part1. Enter the dispase, or complications t shock, or heart failure. List only one cause	hat caused the death. Do not en	ter the mode of dyl	ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Physician			mmune Deficienc	y Syndror	ne			Onset and Death
1.	/Medical		regulting in death)	e to (or as a consequence of):					
	Examiner		Sequentially list conditions, b						
	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a to (or as a nonsequence of):					
	cate be executed obysician and the burial-transit	Examiner	that initiated events c.	e to (or as a consequence of):					
8760,	be e. Sician buria	dical E							
687	ficate physics the	edic	σ.						-
.O. Box	he death certifica r the attending ph ched for use as ti	Physician/Me	in the past 12 months?		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deli Month	very Day Year
Δ.	The law requires that the de tte has been signed by the a bage 2 should be detached to	۵	Part II. Other significant conditions contributing	to death but not resulting in the u	underlying cause gr	ven in Part I.		acco use contribute to	the cause of death?
of Vital Records,	v require been si should I	Completed					24a. Was an	24b. Were au	itopsy findings available
Re	The lavate has	d m					autopsy	ed? prior to death?	completion of cause of
a		e Cc	25. Was case referred to medical			26. Place of Death			2 □ No
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital:	1  Inpatient 2 ER/Outpatie	nt 3 DOA	har		ice 6 Other (Spec	cify)
10	g Phy er thi			Date of Injury (Month, Day Year) 28b. Time (	of 28c. Inju	ry at	28d. Describe hov	v injury occurred	
jo	utending l death. ctor: After y the funer	atio	2 Accident investigation			Yes 2□No			
Division	or A lifter in b	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	6	28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai C	(Check only 2 Medical Examiner: On	o the best of my knowledge, dea the basis of examination and/or in manner stated.	th occurred at the t nvestigation, in my	ime, date and place, opinion, death occurr	and due to the cared at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	- WE (18 18 18 18 18 18 18 18 18 18 18 18 18 1	29c. Licen	se number		d. Date signed (Monti	
	- S - 0		1 Marson C. W	eltem	D2	3743	F	'eb. 13,200	07
	06		30. Name and address of person who completed	cause of death (Item 23a) (Type	, Print)				
	2		Martin O. Weltz, M.D.	7525 Greenway C	Center Dr	., Greenbe	lt,Md.	20770	
2	St Regist	ate rar		32. Registrar's Signature	-				

			1 - For State Registrar	State of Marylan		rtment of F			giene 0 7	06117
	Physici	an	Decedent's Name (First, Middle, Last)	** -1-	• •			2. Date of Dea	ath Day Year	3. Time of Death
	/Medic Examir	al	Marjorie  4a. Facility Name (If not institution, give s 6599 Quercus Drive	treet and number)	imoto	4b. City, Town, o Hebror		Februar	4c. County of Dea Wicomi	
	Funeral Director		130-20-7000	7. Age (In yrs. 7]	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year) C	thpface (State or Foreign ountry) lifornia
	Marylend a-f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Wicomico		y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ № 0
	3e or 28	I Dire	10e. Street and Number 6599 Quercus Drive			10f. Zip Code 2183	30		10g. Citizen of What C USA	ountry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel", or Itema 23a or 28a-f ehow sayl injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 (★No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of we	orking	16b. Kind of Business Publishine	
land 2	ild be fited lental Hygi ked other ic event, i	To Be Co	17. Father's Name (First, Middle, Last)  James Hajime Mits	sui	<u> Payr</u>	oll Spec	18. Mother's Na	ame (First, Middle, 70 Minaka	Maiden Sumame)	9
Mary	nd 2 shou ilth and M 27 ie mar r traumat	-	19a. Informant's Name/Relationship (Typ. Kazuo Hashimoto/hu:					Rural Route Number	or, City or Town, State, 0 21830	Zip Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	emetery, crem	sition (Name of natory or other place Cremator		Date 9/07	20c. Location - City or Salisbury	
Balti	permit. Departm Imports eny inju	9	Sign Him Service License		22 SP 22	Holloway 501 Snow	Funeral Hill Rd	Home Pro	ofessional oury, MD 21	Association 804
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart faifure. List only on Immediate Cause (Finaf disease or condition resulting in death)	e cause on each line.	reatic	or the mode of dyin	g, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	Icai Examiner	Sequentially list conditions, if any feeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						140
P.O. Box 68	The law requires that the death certificate hes been signed by the attending pigned by the attending pigned is should be detached for use as in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	fivery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause giv	en in Part f.		bacco use contribute to	
Division of Vital Records,	n: The law re licete hes ber r, page 2 sho	Completed		-				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
n of Vit	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	on; To Be	25. Was case referred to medical examiner? 1	ospital: 1   fnpatient 2   28a. Date of Injury	ER/Outpatient 28b. Time of Injury	3 DOA Oth	er: 4 🗆 Nursing		nel ence 6  □Other (Spe ow injury occurred	cify)
ivisio	or Attendii after death. Director: A in by the fu	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre	M 1	Yes 2 □ No	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
۵	To the Hospital of within 24 hours a To the Funeral D completely filled in	Medical Ce	29a. Certifier 1 Certifying Phys	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tine	ne, date and plac pinion, death occ	e, and due to the courred at the time, c	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	Io the To the	Me	29b. Signature and title of partifier	and marrier stated.		29c. License	e number	2	29d. Date signed (Mont	h, Day, Year)
2	Wal	IJ	30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Type, F	-	-4127		2/9/	7
V	) ~		flon pars 10	o Power 5-	t. c.	O NI	mn	21804		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 3 20	32. Registrar's Signa	ture	ack !				

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			For State Registrar		State	of Mary	/land /		artmen <i>tificat</i>			nd Me	ental Hyg	iene	. 007	061	18
777	Physici	an	1. Decedent's Name			isa			nkin				2. Date of Deal Month	th Day	/ Year	3. Time of	м
	/Medic Examin		4a. Facility Name (If r	not institution, giv	re street and nu	ım <i>ber)</i>			4b. City,	Town, or	Location of		ebruar	3	, 2007 County of Deat	2250 th	
91				rances							erlan				Alleg	any	
	Funeral Director		5. Social Security Nur 153-46-41	64	Sex 1□M 2□XF	7. Age (Ir 52	n yrs. last	birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day) 11/28/	Year)	Co	hplace (State of buntry) V Jerse	
	land ow		Usual Residence of E 10a. State	Decedent 10b. County		10	c. City, T	own or Lo	cation							10d. Inside Ci	ity Limits
	Mary a-f eh	tor	MD	Allega	ny			(	Cumbe	rlan	d					1 🎇 Yes	2 🗌 No
	or 28	Director	10e. Street and Numb		<i>a</i> .				10f. Zip		F.0.0		1	0g. Citi	izen of What Co	ountry?	
	eath w	erai		? France	S Court		rinIIS	12	Nas Doso		502	in? (Spac	fy Vac or No-		USA 14. Race · Ame	rican Indian	
21215-0036	permit. Pages 1 and 2 should be itled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be multied at 80se.	by Funerai	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4		Armed F	orces? 2∭No ive	1111 0.3.		f Yes, spec	orfy Cubai	n, Mexican,	Puerto R	ify Yes or No- ican, etc.)		Black, Whit		
5-0	72 ho natur	eted		15. Decedent's E		)	1	(Give	ient's Usua kind of wo	nk done d	uring most	of working	9	16b. Ki	ind of Business/	Industry	
121	within ene. then	Completed	Elementary/Second	dary (0-12)	College	(1-4or 5+)			DO NOTU		Mana	gan		∩ff	ice Equ	inment	
	e filed Il Hygi other	Be Co	17. Father's Name (F	First, Middle, Las	')			D 13 01	100	Dares			First, Middle, i			a i pinerro	
<u>ylar</u>	Menta Menta Brked Bric ev	To B	Abraham			Ga	ithe	r			Lil	llian				Allen	
Maryland	12 sho		19a. Informant's Nan	·		ى د	1		_					-	r Town, State, 2		
	Health Health tem 27		Harry Je 20a. Method of Dispo		nuspan		20b. Place	e of Dispo	sition (Nar	me of		, Cum Da	berland te		AD 2150 cation - City or		
Ē	Pages nent of nt: If i	1 Burial 2 Composition 3 Removal from State 4 Donation 5 Other (Specify)  Cumberland Crematory 02/07/200									- 1	007 Cumberland, MD					
Baltimore,	permit. Departm Imports eny inju		21. Signature of Fund	eral Service Lice	nsee /	)	o din b	22	. Name ar	nd Addres	s of Facility	Adam		ly l	Funeral		P.A.
÷ '''			23a. Part1. Enter the shock, or heart	disease, or confailure. List only	plications that	caused the	death. [									Approximat Interval Bet	ween
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Caucht of Stowark with Hetarpson (Year Due to (or as a consequence of):												Death		
Ř	p ii	Iner	if any, leading to imm cause. Enter Underh	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												-	
•	xecute and	Examiner	that initiated events resulting in death) La		c. Due to	(or as a co	neupeano	ce of):							-		
8760,	icate be executed physicien and s the burial-transit	dicai E		·	d.												
9	sertifica ding ph se as t	Φ.	IF FEMALE:	1	23c. If yes, or	steame of a	reananou	,						T			
.O. Box	The law requires that the death certifi ate hes been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?	1 Live	birth 2 nant at tim	Fetal de	ath 3	Ectopic pi Other (sp						23d. Date of del Month	•	Year
rds, P	w requires that been signed t should be deta	þ	Part II. Other signific	cant conditions	contributing to	death but n	ot resultin	ng in the u	nderfying o	ause give	n in Part I.		23e. Did tol		ise contribute to No 3 □ Pr	the cause of dobably 4 DL	
Vital Records,	The law reate hes be page 2 sho	Completed										-	24a. Was a autops perform	Y	prior to death?	itopsy findings a completion of c	available ause of
Vita Vita	ding Physicien: The n. After this certificate he funeral director, page	Be	25. Was case referre		Hospital:					Otho		of Death	Check only on	10)			
	Phys or this seal dii	To	1 ☐ Yes 2 ☑ N 27. Manner of Death	lo	28a. Date	Inpatient of Injury	28	Outpatier  b. Time o		DA Othe 28c. Injury Work	4 LI NUI		e 5 ∏ Reside 3d. Describe ho		6 □Other (Spec	cify)	
ion	ath. rr: After	ation	1 ⊠Natural 2 □ Accident	5 Pending investigation	in	nth, Day Ye	ear)	Injury	м		:? ∕es 2 □ N				•		
Division of	ol or Atten s after death i Director: d in by the	Certification:	3  Suicide 4  Homicide	6 Could not I	288. Plac	e of Injury ding, etc. (S	- At home Specify)	, farm, str	eet, factor	y, office		28	If Location (SI City or Town	treet and	d Number or Ru	ural Route Num	ber,
	To the Hospitei or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edicai (	29a. Certifier (Check only 2 one)	Certifying P	miner: On the	e best of m basis of ex- nner stated	amination	dge, deat and/or in	n occurred vestigation	at the tim	e, date and inion, death	place, an	nd due to the ca d at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s	}
	To the To the Comp	ž	29b. Signature and	Pe of certifier	00			X	290	c. License	_		2		te signed (Monti		
)	10	1	M	(N )	XN	XNV	2	ld-	ソ	D17	526			Fe	ebruary	7, 200	7
	nes		30. Name and address John	ss of person who n N. Meh	anna, 🖹	10	904	Set		rive,	Cumb	erlar	nd, MD	215	502		
(ならながない	Sta Registi		31. Date filed (Month	0 8 200	7	Registrar's	Signature	9	A. I								

1   Yes 2 to No 9   Unknown 9   Unknown 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco use contribute to the cause of death?				1 - For Amend Item 23	State of Maryland a per dr., g86	1 / Depa 5 <b>, 03/2</b>	rtment of h	lealth and Death	Mental Hygi	ene 007	06119
SALLE D JENSTIN STATE OF STATE		Dhusisi			1				3 Date of Death	Day Year	
CONTROL COUNTY OF THE PROPERTY				SALLIE 19	JENKINS				TEBRUA	127 10. 200	7 1.50 A M
Second Second Number   1 Second Second Number   2 Second Second Number   2 Second Second Number   3 Second Number   3 Second Second Number   3 Second N		Examin	er			00 00	4b. Cily, Town, o	r Location of Deat	h		A Quest Ser
205—18—5450   M XF   Garden   Section   Control   Contro							If Under 1 Year	If Under 24 Hrs		9. Bi	rthplace (State or Foreign
Use Plantage of December   100 Cells   1				10			Months Days	Hours Min.	(Month Day	Year) C	Country)
The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James		D		Usual Residence of Decedent					11-		
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The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James		Be-f	cto	2	under Ode	Sucon	T				
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The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James		e 23e	erai			12 V			Specify Yes or No-		erican Indian
The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James	936	urs after de bi', or item xontiner	by Fune	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give				to Rican, etc.)	Black, Wh	ite, etc.
The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James	Ö	2 ho	ted	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	nation	dena 1	6b. Kind of Busines	s/industry
The start is the first, Middle, Last)    The start is the first, Middle, Last)   The start is the first, Middle, Last)   James Bradley   James	2	thin 7	nple			life. L	OO NOT use retire	d)		Cumberla	nd Co.
Dames Drad. Ley    State   Control	N	ygien ygien yer th	Son		lyr	Food	Servic				ystem
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Double Per Johnson Court Service Location 3   Removal from State   Chouse to Science (Service Location 5   Removal from State   Chouse to Science (Service	2	hould d Mer marke matic	၉	-	o Print)	10h Mailin	a Address (Street			City or Town State	Zin Code)
20. Manage of Department of State   20. Location - City or Town. State   20. Location	Z	d 2 s th an treur treur					•				
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Physician (Medical Examinor)  Particular to desage or combinations that cause of each incombination of combinations that cause of each incombination and considerable and consid	ltimo	000		4 ☐ Donation 5 ☐ Other (Specify)	chui	cch C	emetery	2-1			
Physician Medical Examiner    Physician Medical Examiner   Physician Medic	Ba	Depart Person		17-77 H R							
Physician Medical Examiner  The propose of the prop			$\vdash$	23a. Part1. Enter the disease, or compli	cations that caused the death.						Approximate
The state of the s		/Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		neaver.				Onset and Death
The state of the s		D #	iner	il any, leading to immediate cause. Enter Underlying	Que to (or as a consequi	ence of):					
FEMALE:   23d. Date of delivery   23d. Date of deliv		ecute and trans	cam	that initiated events	. Due to for se a conseque	anna att:					
25. Was case referred to medical examiner?  10 years 20 No  25. Was case referred to medical examiner?  10 years 20 No  26. Place of Death (Check only one)  27. Manner of Death  10 years 20 No  28. Date of Injury  28. Date of	90	cien d	Ē	, southing in outsin, and	Due to (or as a conseque	ence on.					
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State Registrar    State Registrar   State Regis	<b>&gt;</b>	nysicl nis ce direc	2 E		ospital: 1 Inpatient 2 🗆 E	R/Outpatien	t 3□ DOA O#	ner: 4 Nursing I	Home 5 ☐ Resider	nce 6 Other (Sp	ecify)
State Registrar  30 Date filed (Month, Da) (Year)  FEB 12 2007  Tehrwany 10 2007  Te		ng Pt fter tt neral			28a. Date of Injury (Month, Day Year)		28c. Inju Wo	ryat rk?	28d. Describe how	w injury occurred	
State Registrar  30 Date filed (Month, Da) (Year)  FEB 12 2007  Tehrwany 10 2007  Te	Sio	endin eath. or: A or: A	catio	2 Accident investigation			M 1	Yes 2 □No			
State Registrar  30 Date filed (Month, Da) (Year)  FEB 12 2007  Tehrwany 10 2007  Te	Dİ	itel or Att rs after d ei Direct led in by I	Certific	dataminad	28e. Place of Injury - At hor building, etc. (Specity)	ne, farm, str	eet, factory, office		28f. Location (Stre City or Town	eet and Number or F State)	Rural Route Number,
State Registrar  30 Date filed (Month, Da) (Year)  FEB 12 2007  Tehrwany 10 2007  Te		in 24 hou he Funer pletely fill		(Check only 2 Medical Examir	ner: On the basis of examinati	vledge, death on and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)
State Registrar  31. Date filed (Month, Da), Year)  FEB 1 2 2007  32. Registrar's Signature	ı	To T To 1	2	29b. Signature and Life of certifier	o mi	>	29c. Licens				
Registrar FEB 1 2 2007 A Registrar		4		Since and 3	or hospita	de	Print) Le El	eu bu	rrue M	10 210	61
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ORIGINAL

Anna Annabel

			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>				N / N * 17	0:100
			Registrar     Decedent's Name (First, Middle, La	st)	Timoato or E	Journ	2. Date of Dea		1001	3. Time of Death	
	Physicia /Medic		SURA	KOSTYUKOVSKAY	A			FEBRUA	ARY 9	, 2007	9:25 A M
J	Examin		4a. Facility Name (If not institution, giv	e street and number)			Location of Death		4c. C	ounty of Death	
_	Funeral		CASEY HOUSE  5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year_	VILLE If Under 24 Hrs.	8. Date of Birtl	n	9. Birthp	ONTGOMERY  place (State or Foreign
	Director		219-43-4733	□ M 2X F	90 Yrs.	Months Days	Hours Min.	(Month, Da) 12/01/	, Year) L916	Cour	KRAINE
	w w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					0d. Inside City Limits
	Maryi -f sho ied at	tor	MARYLAND MONTGOM	ERY G	AITHER	SBURG					1 XXYes 2 □ No
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?
	ath wii s 23a o	ral	19229 WHEATFIELD	·	_ [		20879				S.A.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show them 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		<ol> <li>Race - Americ Black, White, Specify:</li> </ol>	
21215-0036	72 hou natura Jical E	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of work	ting 1	16b. Kind	d of Business/In	dustry
121	vithin ane.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired HOMEMAKER				OWN HO	ME
9	filed v Hygie other i	Be Co	17. Father's Name (First, Middle, Last	)	J	HOTISTAKEK	18. Mother's Nam	e (First, Middle,	Maiden S		ME
/lan	should be I and Mental I s marked o umatic eve	To B	BORUKH AKSELROD				MA	RIA "UNK	CNOWN	†1	
Σ	1 and 2 sho Health and I tem 27 Is ma other traums		19a. Informant's Name/Relationship (MARIYA KOSTYUKOVS			ng Address (Street a					
altimore,	Pages 1 and nent of Heamant: If Item		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Removal from State	cemetery, cre	osition (Name of matory or other plac EML GARDE	e)	Date 1/2007		ation - City or To	
Balt	permit. Pages Department of Important; If It any Injury or o		21. Signature of Funeral Service Lice	nsee	E	2. Name and Addres DWARD SAG 091 ROCKV	EL FUNERA	AL DIREC	TION	, INC.	AND 20852
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not en	ter the mode of dyin-	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
15	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MALIGNANT M		A					
	Examiner	Ш		b.	quence ory.					19	
1	po tis	iner	Sequentially list conditions, it any had not to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):						
•	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):						
8760,	cate be executed physician and the burial-transit	dical		<b>⊸</b> d,							
9		Medi	IF FEMALE:				-41		T		
Division or Vital Records, P.O. Box	The law requires that the death certifiate has been signed by the attending agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a	aldeath 3[	□Ectopic pregnancy □ Other (specify)			23	3d. Date of delive Month	ery Day Year
ري. ح	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use	e contribute to t	he cause of death?
ğ	w require been sig should b							1 🗆 \	′es 2 <b>X</b>	No 3 □ Prot	pably 4 ☐ Unknown
l Reco		Completed						24a. Was autop perfo 1∐ Yes		prior to co	ppsy findings available mpletion of cause of 2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- Othe	26. Place of Deat			_	
ō	ing Phys I. After this funeral di	): To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	TIL 3 DOA	4 LJ Nursing Ho	ome 5 ☐ Residence 128d. Describe h			W HOSPICE
ion		atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 ☐ No				
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		iome, farm, st	treet, factory, office		28f. Location (5 City or Tow	Street and vn, State)	Number or Rura	al Route Number,
	he Hospi n 24 hour he Funer pletely fill	Medical		nysician: To the best of my kn miner: On the basis of examin and manner stated.							
	7/	Σ	29b. Signature and title of certifier	Hillio	rener	29c. License	number 05803)			signed (Month, $-9-2$	
	V		30. Name and address of person who CYNTHIA M. WILLIA				6001 MID	ICA CTED	мттт		20855
	Sta	ite	31 Date filed (Month, Day, Year)	32 Registrar's Sign	ature	HOSE ICE,	OOOI MUN	CASIEK	114444	KU, KU(	NATIFE WD
	Regist	rar	FEB 1 2 20	107 Bour	J A						

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

To the Hosp within 24 hot To the Fune completely fi

State Registrar

LAKHYZNDER 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

WADYNA 400 W. 74h ST. FREDENICK UND 2170, 32. Pagistrar's Signature Stown

and manner stated.

L. WADHWA, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0063498

29d. Date signed (Month, Day, Year)

2-10-2007

			Please	Type or Prin								•		
			For State	State of Ma	arylan		epartment d Certificate			lental Hy	giene	9		0.0
	ă.		Registrar  1. Decedent's Name (First, Middle, La	st)			<i>Jeruncale</i>	oi De	alli 	2. Date of De	Reg. No	200	3. Time of D	eath
	hysicia	_		carelli						Month 02	Da	y Year		
	/Medic xamin		4a. Facility Name (If not institution, given				4b. City, Tov	vn, or Loc	ation of Death	02		. County of De	1 1 1	<u>'</u>
			University of Maryl	and Medical	Cen	ter		time						
	neral		5. Social Security Number 6.	Sex 7. Age 1 □ M 2 ☐ F	e (In yrs. I		day) If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D	ay, Year)	)   (	irthplace <i>(State or F</i> Cou <i>ntry)</i>	Foreign
Dir	ector		173-24-8296 Usual Residence of Decedent		77					FEB 1,	193	80   Per	nnsylvani	a
yland	at at		10a. State 10b. County		10c. City	, Town	or Location						10d. Inside City	
e Mar	a-f st	ctor	Virginia Fairfax		Alex	xand	ria						1 ☐ Yes 2	2 📉 No
ith th	or 28	Funeral Director	10e. Street and Number				10f. Zip Co				Ü	tizen of What C	•	
ath w	s 23a nust I	eral	7161 Silver Lake	Blvd. #229	Ever in II	e	223		oio Origin? (Sp	ooifu Voo or N		ted Sta		
ter de	ner n	Fun	11. Marital Status 1 □ Never Married 2 X Married	Armed Forces?	ver in o. No	S.	13. Was Deceden If Yes, specify		exican, Puerto	Rican, etc.)	0-	Black, Wh	ite, etc.	
urs af	al", or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣	No Sp	ecify:			Specify: W	hite	
72 ho	natur Iical I	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. [	Decedent's Usual C Give kind of work of life. DO NOT use r	ccupation	a most of work	ina	16b. K	(ind of Busines	s/Industry	
ithin in	han " e Mec	hgm H	Elementary/Secondary (0-12)	College (1-4or 5	+)			etired)	,	J				
iled w	ther t	e Co	12 17. Father's Name ( <i>First, Middle, Las</i>	*)		non	nemaker	18.	Mother's Nam	e (First, Middle		n Home		
d be i	c eve	m	Morris A. Shaffer	,						Brenna		,		
shou	umat	۲	19a. Informant's Name/Relationship	(Type. Print)		19b. l	Mailing Address (S					or Town, State	Zip Code)	
and 2	n 27 is ertra		Phillip Luccarell	i/Son			11 Middle							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.	r oth	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	A Removal from State	C	emetery	Disposition (Name of crematory or other	r place)		Date	20c. L	ocation - City o	or Town, State	
. Pag tment	tant: jury o		4 □ Donation 5 □ Other (Spec	fy)		ark	ax Mémor			7/2007	Fa	irfax,	Virginia	
Depar Depar	Impor any In once.		21. Signature of Funeral Service Lice				22. Name and A Fairfax 9902 Bra	ddress of Memo	rial F	uneral	Home		2.0	
			23a, Part1. Enter the disease, or cor	AUXL CCO	the death	n. Do no						A 220:	Approximate	
Dhye	sician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.						,		Interval Betwee	
	edical		disease or condition resulting in death)	a. IVYLVLV Due to (or as			etabolic	- 9	C1 a OS1	5	<del></del>			
Exar	niner		Sequentially list conditions	h										
p	#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of	·):							
ecute	and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of	······································							
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ificate	g phys	Physician/Medica		d										
h cert	anding use	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			3 □Ectopic pregi	nancy				23d. Date of d		
deat	ne attr	sicia	in the past 12 months? 1 □ Yes 2 \ No	4□Pregnant at			5 ☐ Other (speci					Month	Day Ye	ear
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ires t	signe d be d	by	Coronay art	1.10		ve Ce			y ar-				Probably 4 12 Uni	
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ysici.	direct	To Be	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 XInpatie	ent 2	ER/Outp	oatient 3 DOA	Othor:				6 ☐Other (Sp	ecify)	
5 H	fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Yea <i>r)</i>	28b. Ti Inj	me of 28c.	Injury at Work?		28d. Describe	how inju	iry occurred		
tendi eath.	tor: A	catio	2 Accident investigation 3 Suicide 6 Could not l				М	1 ☐ Yes	2 □No	201 1 "	(0)			
or At	Direc in by	Certification:	4 ☐ Homicide determined		ury - At no c. <i>(Specif</i> )	me, tarr	n, street, factory, o	пісе		City or To	(Street a own, Stat	nd Number or i e)	Rural Route Numbe	er,
spital ours	neral / filled		29a. Certifier 1 🔀 Certifying F	hysician: To the best	of my kno	wledge,	death occurred at	the time, o	late and place	, and due to the	e cause(s	s) and manner	as stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 ☐ Medical Exa one)	miner: On the basis o and manner sta	f examina ated.	tion and	or investigation, in	my opinio	n, death occu	rred at the time	e, date an	nd place, and d	ue to the cause(s)	
To th	To the	Ž	29b. Signature and title of certifier				29c. L	icense nu	mber		29d. Da	ate signed (Mo	nth, Day, Year)	
2	-		Miller	ho			AU4	1164	35MIL	,779	2	18/200	) /	
			30. Name and address of person who	0.		1		12.	Line	D INT	7	1201		
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signa	₹VU iture	CNR 31.	10a	Minney	t, PU	0	1001		
ı	Registr		FEB 1 2 20	Ul Born	n sta	3	porte					·		

Betty G. Luber State of Maryland / Department of Health and Mental Hygiene 2007 06123 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 10, 2007 Medical Examiner 0900 hrs Betty G. Luber 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Chevy Chase Montgomery 8100 Connecticut Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs 7. Age (In yrs. last birthday) **Funeral** Months Days Min Hours Director Country MD 1 M 2X F 94 12/4/1912 577-12-9852 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any 1 X Yes 2 No 23a or 28a-f show notified at once. 28a-f show Chevy Chase Montgomery Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 8100 Connecticut Avenue # 1401 20815 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wit
Department of Heath and Mental Hygieth
I filed 27 is marked other than "natural", or items 2
injury or other traumatic event, the Medical Examiner must be n If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Divorced 3 X Widowed Yes, Give Year 1 Yes 2 X No specify: White <u>Ş</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacist Medical 8.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Haft Louis J. Gitomer Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 West Kersey Lane Potomac MD 20854 Joseph Luber - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 2/12/07 Olney, MD 4 Donation 5 Other Specify:
21. Signature of Funeral Service Deensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 22. Name and Address of Facility Approximate Interval 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Į, 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 Vunknown σ. Diabetes mellitus Completed Records, 24b. Were autopsy findings available 24a, Was ar certificate has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) To the Hospital o Attending Physician: 25. Was case referred to medical of Vital Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Division 5 Pending the f after death. within 24 hours after death To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 10 February 11, 2007 O.C.M.E. al 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signature 31. Date filed (Month Pay Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06124 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Walter Labanow 6:07 P. M February 7, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ★M 2 F 89 716-01-4872 Pennsylvania Sept. 28,1917 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Montgomery Chevy Chase Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4615 N. Park Avenue Apt. 1113 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1⊠Yes 2□No If Yes, Give 1940–1941 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Administrative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wasil Labanow Viola Lanchak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Labanow/ Sister 5480 Wisconsin Avenue, Chevy Chase, MD 20815 20b. Place of Disposition (Name of camelery, crematory or other place),
Georgetown University Feb. 10
2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4X Donation 5 ☐ Other (Specify) Washington, D.C. 21. Signature of Funeral Service Lies 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Interiorderota Due to (or as a consequence of): Sequentially list conditions if any, leading to infinitedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Marrier of Death 1 Natural 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner pe ۵ Vital Records, after death.

Director: After this certifica abano W. Division or Hospital within 24 hours a

**Physician** 

/Medical

Director

Funeral

S Q

Completed

Be

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Examiner

Physician/Medical

Completed by

Certification: To Be

Medical

filled in by the

been signed by the atter should be detached for u

**Examiner** 

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

State DHMH 17 Rev 1/2001 4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

determined

OTHSTEIN, M.D.

32 egistrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Detedent's Name (First, Middle, Last) 2. Date of Death Day - Month Year 1/ 200 Eacility Name (If not institution, 4b. Cit Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In/y rs. last birthday, If Under 1 Year Days Hours Min. 1 X M 2 □ F 53 213-68-3400 01/10/1954 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21701 119 E. 4th Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction <u>Painter</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leona Bruce Long Webster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12401 Snyder Drive, NW., LaVale, MD

**Physician** /Medical

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Leona P. Long / mother

Director

Funeral

Completed by

Be

္

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner

burial-trar attending ph for use as t signed by the a d be detached f page 2 this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Division or Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Remov	al from Ctota	<ol> <li>Place of E cemetery,</li> </ol>	isposition (N crematory o	lame of r other place)		Date	20c. Loc	ation - City or	r Town, State	
	4 □ Donation 5 □ Other (Specify)	ai iroin State	Cumber	Land C	rematory	y 02/1	14/2007	Cum	berlan	d, MD	
Ī	21. Signature of Funeral Service Licensec			22. Name	and Address of	Facility Ac	lams Fam:	ily F	uneral	Home,	P.A.
	Kulut C. Hal			404	Decatur	Stree	et, Cumbe	erlan	d, MD	21502	_
1	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau									Approxim Interval E Onset an	etween
	Immediate Cause (Final disease or condition resulting in death)	Neuroe Due to (or as a	indouri	ne 1	mall	Cell	cancer	ما		6 VV	rtho
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a c	orisequence of	):	Dise	دعوره				1ye	ar
	in the past 12 months?  1 Yes 2 No 9 Unknown	yes, outcome pf Live birth 2 Pregnant at tir Unknown	Fetal death ne of death	3 ☐Ectopic 5 ☐ Other	specify)				3d. Date of de Month	Day	Year
	Part II. Other significant conditions contribut	ing to death but i	not resulting in t	he underlying	cause given in	Part I.		tobacco us	se contribute t	o the cause o robably 4 [	
							24a. Was auto perfo		death?	utopsy finding completion of	s available cause of
ľ	25. Was case referred to medical examiner?				26.	Place of De	eath (Check only o	one)			
	1 Yes 2√1 No Hospita	al: 1 Inpatient	2 ER/Outp	atient 3□ I	Other: 4	☐ Nursing I	Home 5□Resi	idence 6	Other (Spe	ecify)	-
	1 Ablatural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury (Month, Day Y	/ear) 28b. Tir	ne of ury M	28c. Injury at Work? 1 ☐ Yes		28d. Describe				
	3 Suicide 6 Could not be 4 Homicide determined 280	e. Place of injury building, etc.	- At home, farn (Specify)	n, street, fact	ory, office		28f. Location ( City or To	Street and wn, State)	Number or R	ural Route N	umber,
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Care and the control of the control	: To the best of on the basis of earth	xamination and/	death occurre or investigati	ed at the time, do	ate and place n, death occ	ce, and due to the curred at the time,	cause(s) , date and	and manner a place, and du	s stated. e to the cause	∋(s)
4	29b. Signature and title of certifier	1 1 1	A 4-	2	9c. License nun	nber		_	signed (Mon		)
	March hand	lool,			Res-	201	)	Fehr	Iani 1	1 250	7

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State Registrar 600 North Wolfe Street Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anil Trindade, MD

(Month, Day, Year)

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year ice A. Marx рм /Medical February 9, 2007 9:00 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Holy Cross Rehab. & Nursing Center Burtonsville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Hours 1 ☐ M 2 ☐ √F Yrs. Director 205-10-6088 Feb. 11, 1921 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ or Items 23a 603 McNeill Road 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White γ 1 ☐ Yes 2 No Specity: 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph McNulty Lucetta Koerner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin H. Marx/ Husband 603 McNeill Road, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 15, 0 permit. Page Department of Important: If any Injury or '4 □Donation 5 ₺Other (Specify) Entombment Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Adress Compins Funeral Home Inc. - Kein Skile 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Advanced Demontic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to inniversitate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsaquance of): Examiner executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached à Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 1 ☐ Yes 1 🗌 Yes 25 No 2 **N**0 Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4. Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: After 28d. Describe how injury occurred Division Injury 1 🗷 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 24 hours a 29a. Certifier La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D6054566 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli 1220-A East Toppa Road selle 30, TOWSON MD21286 31. Date filed (Month, Pay, Year) FEB 1 2 2007 legistrar's Signature State Registrar

			For State of State of Registrar	Maryland / Dep <i>Ce</i>	artment of Heal rtificate of Dea		ygiene Reg. No. 2007	06127
ľ	Physicia	an «	1. Decedent's Name (First, Middle, Last)	163		2. Date of E	Death Day Year	3. Time of Death
	/Medic	al	EDWARD W  4a. Facility Name (If not institution, give street and num.		GRUDER  4b. City, Town, or Local	FEBRUA	ARY 12, 2007	4:30P M
}	Examin	4	FREDERICK MEMORIAL HOSP	ITAL	FREDERICK		FREDERIC	X
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday,	Months Days Ho	nder 24 Hrs. 8. Date of E (Month, L) Nov. 2		thplace (State or Foreign ountry) ryland
	yland now at		10a. State 10b. County	10с. City, Town or L	ocation			10d. Inside City Limits
	e Mar Ba-f sl	ctor	Maryland Frederick	New Mar	ket			1 ☐ Yes 2 🛣 No
	Sa or 2	Dire	10e. Street and Number 11125 Pond Fountain Co	urt	10f. Zip Code 21774		10g. Citizen of What Co	ountry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🛣 Divorced  12. Was Dece Armed For 1 □ Yes If Yes, Giv. Year or Da	2 🔀 No e		ic Origin? (Specify Yes or N xican, Puerto Rican, etc.) ecify:	No- 14. Race - Ame Black, Whit	
21215-0036	vithin nne. han "	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-12)	-4or 5+) (Give	edent's Usual Occupation e kind of work done during DO NOT use retired) ice Manager/		16b. Kind of Business. Corrugated	d Cardboard
	e filed al Hygi other vent, ti	Be Co	17. Father's Name (First, Middle, Last)	1		Mother's Name (First, Middle	le, Maiden Surname)	
ylar	should be filed vind Mental Hygies marked other tumatic event, the	To	Leon Leamon Magruder			ildred Cornw		
Maryland	d2 tha t7 Is		19a. Informant's Name/Relationship (Type. Print)  Leon L. Magruder - Broth			lumber or Rural Route Num Kill Devil		
	os 1 ar of Heal item 2	133	20a. Method of Disposition	20b. Place of Disp		Date	20c. Location - City or	
Baltimore,	Page ment c ant: If	١.	1 ☐ Burial 2 【Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	Metropol	itan Cremato	rium 2/15/07	Alexandria,	, Virginia
Balt	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licenses	$\frac{1}{2}$	2. Name and Address of F olesworth—Wi 6401 Ridge R	acility Iliams P.A., oad, Damascu	Funeral Homes, Maryland	ne 20872
В			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	ach line.		•		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	9STRO IN or as a consequence of):	TESTINA	L BIEE	D	DAYS
	Examiner		EM		LIVER	DISEAS	SE	MONTHS
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68760,	icate be executed physician and the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last c	or as a consequence of):				
P.O. Box 6	death certiff e attending ed for use as	Physician/Mec	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
	uires tha signed d be de	þ	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause given in f		tobacco use contribute to	
al Records,	The ate har page	Completed					opsy prior to death?	utopsy findings available completion of cause of
Vital		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ II	npatient 2 ER/Outpatie	Other:	Place of Death Check onl		
JO L		$\vdash$	27. Manner of Death 28a. Date			□ Nursing Home 5 □ Re 28d. Describe	e how injury occurred	icity)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of injury - At home, farm, st	M 1 ☐ Yes	28f. Location	(Street and Number or Ri own, State)	ural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the band mann	asis of examination and/or i	ath occurred at the time, dance of the time, dance	ate and place, and due to the time, death occurred at the time	ne cause(s) and manner as e, date and place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	14.5	29c. License num		29d. Date signed (Mont	- '
	6		The	MD	200619	10	Feb, 13,	2007
			30. Name and address of person who completed cause Graffar Syed, M.D. 801	e of death (Item 23a) (Type Toll House A		erick. Marvla	and 21701	
1	Sta Registi			gistrar's Signature			21/01	
			( F.D. 7 o COOL	- Ja /3/				

Division or Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital o

ernic

Registrar

31. Date filed (Month, Day, State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

14 2007

D. 650162 ECIL 11.0.

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2-7-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

7525 GLEENWAY CENTON DRIVE SOITE 113 GREENBELT, ND 20770

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year May Mullinix 2, 9:20P 2007 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □X 577-40-1461 Yrs Director 78 Oct. 6, 1928 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Carrol1 Maryland Mount Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 613 Calliope Circle 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Gordon, Sr. Louise Seek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2160 Route 94, Woodbine, Maryland Greg L. Mullinix - Son 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mt. Carmel Cemetery 2/07/07 \* 4 □ Donation 5 □ Other (Specify) Sunshine, Maryland 22 Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
20401 Ridge Road, Damascus, Maryland 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20872 Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 Days Pulmonary Embolism disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and d-transit The law requires that the death certificate be executed physician a Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) by the a 9 Unknown á signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 TUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed page this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: ector. Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After I 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL 10005999 February 5, 2007 10 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) John C. Abel M.D. 295 Stoner Avenue - Suite 307, Westminster, Maryland 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Aprile 0 Registrar 8 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 9 2007 0054 James McGowan /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb 22 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 19<u>29</u> **Funeral** 1**∑** M 2□ F 77 Yrs. 213-22-0899 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or then "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at ty∏Yes 2 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21401 221 Croll Dr. death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1951-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married Specify: Black 1 ☐ Yes 2 ☐ Wo Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. al Hygiene. Coilege (1-4or 5+) Elementary/Secondary (0-12) Board of Education Custodian 6th 0 treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) t of Health and Mental Hy if item 27 is man-17. Father's Name (First, Middle, Last) John W. McGowan Nola Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Md. Lillian R. McGowan(Wife) 221 Croll Dr. Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) permit. Pages Department of Importent: if it any injury or c ō Maryland Veteran 2-14-07 Crownsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Win Name Release of Each Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 1800 MOG48 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic obstructive exacerbati **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rena performed . 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Kepatient 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide ö within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 12

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007

4b. City, Town, or Location of Death

SAUSBUY

If Under 1 Year If Under 2 Hrs.

Months Days Hours Min

miles

CENTER

Montrell

MEDICAL

4a. Facility Name (If not institution, give street and number)

Peninsula Regional

3. Time of Death

Birthplace (State or Foreign Country)

4c. County of Death

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2005 M

1 - For State Registrar Physician /Medical Examiner Funeral Director

2	Funeral Director		5. Social Security Number n/a	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. las	st <i>birthd</i> ay Yrs.	) If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Bir (Month, Date 2/7/2	ıy, Yea <i>r</i> )	9. Biri Co	thplace (State or Foreign buntry) ryland
Н		1	Usual Residence of Decedent	I						2/1/	2007	l'id.	Lytalia
	yland now at		10a. State 10b. County	′	10c. City,	Town or L	ocation						10d. Inside City Limits
	should be filed within 72 hours after death with the Maryland ind Mental byglene. Ind Mental byglene. Inarked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	형	Maryland Some	erset		Cris	field						1 X Yes 2 No
	or 28%	ire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?
	th wit	al	246 Somers C	ove			2181	7			US	SA	
	deat	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U.S.	. 13.	Was Decedent of I	lispanic Ori	igin? (Speci	ify Yes or No	)- 1	4. Race - Ame	
0	or its		1X Never Married 2 ☐ Mar	ried 1 ☐ Yes If Yes. G	2 <b>Z</b> No ive		1 ☐ Yes 2 XNo			,,		Black Whit Afr SpecifyAme:	
0000	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:								
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V	withir ene. than	g I	Elementary/Secondary (0-12)	College n/a	(1-4or 5+)			۵,			_	/-	
7	filed Hygir ther ant, th		n/a 17. Father's Name (First, Middle				ı/a	18. Mothe	er's Name (	First, Middle		M/a Surname)	
מ	ould be Mental arked o atic eve	o Be	Keon Montrell					Тε	kisha	Jara	a Jac	kson	
<u></u>	2 should and Me is mark	2	19a. Informant's Name/Relation			19b. Mail	ling Address (Street						Zip Code)
<u>0</u> .	and 2 sealth ar		Takisha J. Ja		her		Somers (						
ก	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene if Health and Mental Hyglene if show flem 21 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	·	20b. Pla	ice of Disp	osition (Name of ematory or other pla	(ce)	Da	te	20c. Loc	cation - City or	Town, State
2	Pages nent of I ant: If Ite ury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		State Wice		Memoria.	Park	2/1	.2/07	Sal	isbury	, MD
Dallillo	ortar		2 Sig. ature of Funeral Service	,	ļ	2	22 Name and Addr	ess of Facili	±31 Hc	mo Pro			
ŏ	permit. Pages 1 and 2 . Department of Health a limportant: If Item 27 is any Injury or other tran	(	N Joseph At.	Dompso	O CES	\$P	501 Snow	Hill	Rd.,	Salis	oury,	MD 218	Association 304
	,		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that	caused the death.								Approximate Interval Between Onset and Death
	Physician <sup>*</sup>	K 4	Immediate Cause (Final disease or condition		Neme pre		(2) (Eg)						Onset and Death
	/Medical		resulting in death)		(or as a conseque		, Iran						
	Examiner <sup>.</sup>		Premachine Labor										
	D =	ner											
	nd	Examiner	C										
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			30. Name and address of person		use of death (Item 2	23a) (Type	e, Print) MARCIS PI	1	11110	hilal	mn		
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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 16a per FH 2/12/2007 AACO GSR State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 Physician February 9:09 Рм Suzanne Borne Nicholson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 17 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√X Massachusetts 50 025-50-7043 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21401 225 Wardour Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by White 3\\ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) hamemeker Mother Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet B. Lyon of Health and Menta item 27 Is marked Lewis Borne 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Wardour Drive Annapolis, Maryland 21401 Bernard Jammet / Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stephens Cemetery 2/12/2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John M. Taylor Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Lico Mich Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the bunial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, sign( Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has e 2 page certificate 1□ Yes 2 - No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA ٩ this After thi funeral ( Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Division 1 Invatural Injury 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12) Rd Ste 300 Annepoles ino 32. Registra Signature 31. Date filed (Month, Day State 2 2007 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death **Physician** 8, 2007 February 7:45 AM Darvin Ocampo Rogelio /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery If Under 24 Hrs. | 8. Date of Birth Hours | Min. | 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1⊠M 2□F March 12,1931 Philippines 213-19-9263 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1⊠Yes 2□No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 532 West Deer Park Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: À 3 Widowed 4 Divorced Filipino Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Material Specialist Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Lucila Darvin ၉ Ignacio Ocampo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 West Deer Park Road, Gaithersburg, MD. 20877 Felicidad V. Ocampo/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/07 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licer 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Cardiac Arrhythmia Due to (or es a consequence of): Examiner b Congestive Heart Failure Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension, Dementia, Chronic Obstructive Lung Disease þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 28 No 1 ☐ Yes 2 ☐ No

Examiner tha attending physician and chad for usa as tha burial-transit The law requires that the death cartificate be executed cate has been signed by tha a page 2 should be datached it To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this cartific complately filled in by the funaral director,

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

**Funeral** 

Director

parmit. Pages 1 and 2 should be filad within 72 hours aftar daath with the Marylan Daparlment of Haath and Mantal Hygiana. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at PARS.

Baltimore, Maryland 21215-0020

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25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 TX No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 K Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, end title of certifier 29c. License number

D 28656

Shady Grove Road, # 208, Rockville, Maryland 20850

February 8, 2007

State Registrar

DHMH 16 Rev 6/95

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Ravi Passi, M.D.,

31. Dete filed (Month, Day, Yeer)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits		
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.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea	ath 3	Ectopic pre Other (spe		_				Date of delive	ery Day Year		
of Vital Records, P.	quires that n signed t uld be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use									_	he cause of death?			
900	e law requir has been si je 2 should	Completed	Aortic I	nouffrei	enly						24a. Was a		b. Were auto	psy findings available		
al R		Сош	autopsy prior to completion of car performed death?  1 Yes 2 No 1 Yes 2 No										_			
V.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	r		(Check only or					
	Phya er this eral di	H- 1	1 Tes 2 No 27. Manner of Death	1 ∐ Inpati	ury 28t	Outpatien  o. Time of		A	4 LI Nu		e 5 Resid			y)		
ion	Attanding ir death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Da	ay Year)	Injury	М	3c. Injury Work 1 🗆 Y	? ′es 2 🗆 1							
Division	al or Attanding P safter death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 28e. Place of In	ijury - At home, tc. <i>(Specify)</i>	farm, str	eet, factory,	office		28	Bf. Location (S City or Tow	treet and Nui n, State)	mber or Rura	I Route Number,		
	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 ☐ Certifying 2 ☐ Medicel E	Physicien: To the best exeminer: On the basis of and manner s	or examination	lge, death and/or inv	occurred a	t the time	e, date and inion, deat	d place, ar th occurred	nd due to the c	ause(s) and late and plac	manner as st	tated. the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier	100			29c.	License	number		2	29d. Date sign	ned (Month,	Day, Year)		
)	WILA		· Illita	YYY				00	5191	24	(	ebru	ary	2,2007		
	10+1		30. Name and address of person v	who completed cause of	death (Item 23:	a) (Type,					D W.	4/1.00	ter V	40 21102		
	Sta	te ar	31. Date filed (Month, Day, Year) FEB 1 2	32. Regist	rar's Signature		bare				100	- court	. (8	V 1.00		

		1	For Stata Registrar		f Marylan	•	artmen rtificate				R	ag. No.	07	061	36
	Physicia		Decedent's Name (First, Middle     Donald Lean		erson						2. Date of Dea Month Februar		2ŎÖ7	3. Time of 1:30	
	/Medic Examin		4a. Facility Name (If not institution 1401 High Stre	, give street and nu					Location o	of Death	repruar	4c. County of Death Carroll			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under	24 Hrs.	8. Date of Birth	Year)	9. Birth	place (State o	r Foreign
	Director	-	218-74-4227 Usual Residence of Decedent	1 <b>2</b> M 2□F	48	Yrs.	INIOIILIS	Days	Tiours		July 21	, 1958		nsylva	
	yland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	Y.7			·			10d. Inside Ci	
	he Mai	ector	Maryland Carro	)TT			104 75		stmin	ster		IOn Citizen of I	1 ☐ Yes 2 No		
	3a or 2	Funeral Director	10e. Street and Number 1401 High Stree	et			10f. Zip	Code	21	158		•	USA		
	r death	nera	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U	er in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - An Black, Wh									
36	ırs afte II', or II	by Fu	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 □ Yes If Yes, Gi Year or D	VO .		1 ☐ Yes	2 🔀 No	Specify:			Specify	v: wh	ite	
21215-0036	72 hou	eted	15. Decedent (Specify only highes	's Education it grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa	ation Juring mos	t of workin	g	16b. Kind of B	usiness/Ir	ndustry	
127	within lene. then	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	Deal		)			Anti	.ques		
פ	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "netural", or Items 23a or 28a-f show afte event, the Madical Examinar must be muitified at	Be C	17. Father's Name (First, Middle,									Maiden Suman	ne)		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygierie.  In marked other then "netural", or Items 23a or 28a-1 show the marked other then "netural", or Items 23a or 28a-1 show the marked other than 10 marked and the marked the marked than 10 marked and 1	욘	Donald M. Patterson Pauline M. Wantz  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S									State, Zi	D Code)		
E ⊠	and 2 salth an		Pauline M. Pat		other		-					, MD 21			
ore	permit. Pages 1 and 2 should be Department of Heatils and Menta Importent: If item 27 Ie marked eny injury or other treumatic et once.		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation	3 □Removal from	_ (	Place of Dispo cemetery, crea uth	osition (Nari matory or o	ne of ther plac			ate (COC)	20c. Location			
altimore,	artmen ortent; injury e.		<ul><li>'4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>		Ca 01191	rroll	Crema 2. Name an	tory d Addres			/2007 ers_Dur	wini boraw F	ield	•	Α
ä	Dep Imp		Austri R. I	Surlund						~ ~_7 `		ster, M			
b	Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a											Approximat Interval Bet Onset and	ween Death
ı	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):									0011
Ţ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec	quence of):							$\neg$		
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760,	ate be executed hysician and the burial-transit	calE		d						· · · · · · ·					
0x 68	death certifica attending ph for use as th		IF FEMALE:	23c. If yes, ou	itcome of pregn	ancv						23d Da	te of deliv	(0.0)	
.o. 80	the death y the atten ched for u	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown 1										Date of delivery  Month Day Year		
۵.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant condition	ons contributing to c	death but not res	sulting in the u	inderlying c	ause give	en in Part I	,		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Monknown			
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed									24a. Was a autop perfor	med?	prior to co death?	opsy findings ompletion of c	available ause of
Vita	ding Phyeicien: The In. h. After this certificate ha funeral director, page	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only of			-1	
o	g Phye er this eral di	n; To	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time o		28c. Injun Work				ence 6 Oth		ify)	
sion	Attending r death. ector: After y the fune	catlo	1 Accident  2 Accident  3 Suicide  6 Could	gation			М	1 🗆 '	Yes 2□		101			15	
Division	after d after d Direct Jinby	Certification:	4 Homicide determ	ined 286 Plac	e of Injury - At h ling, etc. <i>(Speci</i>		reet, tactor	y, office		2	City or Tow	itreet and Numb n, State)	ier or Hur	ai Houte Num	Der,
	To the Hospital or Attendi within 24 ours after death. To the Funeral Director: A completel, filled in by the fu	Medical C		ng Physician: To th Examiner: On the l and mar											;)
i.	To th withir To th	Ř	29b. Signature and title of certifie	Mo			290		SZa:	35		29d. Date signe	d (Month,	Day, Year)	17
•	WIL		30. Name and address of person			m 23a) (Type	Print)	- V				19)	-	200	
			BIND CHAC	1KD 26	Redistrar's Sign		Wen	re	U.	stim	unifer	14	2	1157	
	Sta Regist		FEB 1		Electrical	K.	book								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 **Physician** NOVING 06 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days June 9, 1916 New Mexico 90 Director 467-16-5194 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 XYes 2 No Directo Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 United States 130 Sumner Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No White Specify. ģ 3 Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) <u>Home Maker</u> <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen May Schwoerke Pinkey LaFayette Gunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai Richard Goodwin / Personal Rep. 326 E. Buckingham Way Fresno, CA 93704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 
☐ Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem. Gardens 2/10/2007 | Annapolis, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner S. giornicity in conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【JUnknown page 2 should been s Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy The performe 1 ☐Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient ဥ After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

02.06.07 Name and address of person who compared cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year) 2 2007 FEB Registrar

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of gertiff

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** URNELL DNUIELL 1mol H 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENERA HTLANTIC 7. Age (In yrs. last birthday) DRCESTER Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** DOD Oslan 3007 Days Min. Hours 1 M 2 □ F 218-48-840S Usual Residence of Decedent Director Yrs. 10a State 10b. County 10c. City, Town or Location or 28a-f show Od. Inside City Limits traumatic event, the Madical Examiner must be notified at Tes 2 No Funeral Director BERLIN DRCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10263 MOAD RISON 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or ryes, Give Year or Dates: ARMY 1 ☐ Yes 2 No Specify: δ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 03/02/1951 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) DUPERMSOR permit. Pages 1 and 2 should be file.
Department of Health and Mental Humbortant: if item 27 is meritany or other: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOSES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERLIN MD 20c. Location - City or Town, State ~ WIFE 10265-HARRISON DANGTTE K. YURNELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State PAUL'S CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility BENNIE SMITH 7-W. ISABELLA ST, SALISBURY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) O. Box 68760 Physician/Medical ate hes been signed by the ettending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform V. ⊥ Vital 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Medical Certification: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ŏ 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred <u>o</u> Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exemples. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30 ame and address of person of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State FEB 1 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMN TIFM/17 18, per FH 0865 3/6/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Fujiko Queen 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 10 9. Birthplace (State or Foreign Country)
Japan Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F 82 Yrs. 1924 Director 217-56-4167 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathh and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me. A.al Examiner must be notified at 1 ☐ Yes 2 🙀 No Maryland Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Hickory Point Rd. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Asian Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Domestic Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Kihachi** <del>Unobtainable</del> Takehara Toju Unobtainable ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Solomon R. Queen Sr. (Husbahd) 358 Hickory Point Rd. Pasadena, Md.21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Buria! 2 □ Cremation 3 □ Removal from State Arlington National 2-26-07 Arlington, Va. 4 Donation 5 Dother (Specify) Winhame Reddes of & Cacilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lavy 821 West St. Annapolis, Md. 21401 B. Reese MOO483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASLULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law seem of the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 21X No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 07, 2007 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Neg

2007

DHMH 17 Rev 1/2001

Veterans

Registrar's Signature

Suite 204 Millarsville MD 21108

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Badger Russell, 10, 2007 6:25 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesua

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Dec. 25, 19 Suburban Hospital Montgomery 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 72 1934 Director 152-26-9648 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 2 any injury or other traumatic event, the Medical Examinar mines once. 20910 USA 8510 Bradford Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊡xYes 2 □ No If Yes, Give Year or Dates: 1954-74 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Special lack þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Specialist Personnel Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Badger Russell, Sr. Alma Hurley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 7112 Bridle Path Lane, Hyattsville, MD 20782 19a. Informant's Name/Relationship (Type. Print)
Sheila C. Russell/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 1, 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cemetery 4 Donation 5 Dother (Specify) Arlington, Virginia 2007 21. Signature of Juneral Service License Francis descriptins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** 3 Days /Medical Due to (or as a consequence of): Examiner Lung Cancer Unknown Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical as for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Brain Tumor page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2∏ No 1 Sinpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1x Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) d37891 February 11, 2007 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Rajvanshi, M.D. 121 Congressional Lane, #400, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)

FEB 1 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:20 a M February 8, 2007 Leon Rouff /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1**X** M 2 □ F 83 September 17,1923District of Columbia Director 579-<u>20-695</u>2 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 10a. State 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 15107 Interlachen Drive, Apt. 1019 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1₹ Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2K Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ Year or Dates: 3 Widowed 4 Divorced WWIT Caucasian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clothier Private 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Samuel Rouff Julia Levy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley Rouff - Wife 15107 Interlachen Drive, Apt. 1019, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2007 Rockville, Maryland & Menorah Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Mydin T. Klobert 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed End Stage Parkinson's Disease burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical the Physician: The law requires that the death certificate IF FEMALE: nse : 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 COther (Specify) Hospice Hospital: 1 ☐ Yes 2x No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Μ 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 Aulliams DO H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 12

egistrar's Signature

Cynthia M. Williams, D.O., Montgomery Hospice, 6001 Muncaster Mill Road, Rockville, Maryland 20855

			For State		f Marylar	id / Depa		of H	ealth ar		ental Hy	giene	007	06142
			1. Decedent's Name (First, Middle, La	etl		Cei	uncale	OIL	Jean	1 2	2. Date of Dea	Reg. Nó	001	3. Time of Death
	Physici	an	Frank Ricucci	.0.,						-	Month	Day	Year	8:55 P M
	/Media		4a. Facility Name (If not institution, gir	ve street and nut	nber)		4h. City	Fown, or	Location of		ebruar		2007 County of Death	
	Examir	ier	Upper Chesapeak			or			Air				Harfo	
	Funeral		5. Social Security Number 6.3	Sex	7. Age (In yrs.		If Under	1 Year	If Under 24	4 Hrs. 8	Date of Birt	h Voorl		place (State or Foreign ntry)
1	Director		577-24-9360	M 2 □ F	82	Yrs.	Months	Days	Hours	Min. F	Date of Birt (Month, Day eb. 29	19	24 Wash	ington, DC
_	D .		Usuel Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	oation							10d. Inside City Limits
	ath with the Marylan 23s or 28s-1 show	ō			100.01									1 ☐ Yes 2½ No
	the A	Director	Maryland Harf  10e. Street and Number	ora		вет	Air 10f. Zip	Code				10a. Citiz	en of What Cou	ntry?
	3a or	<u> </u>	1005-B Running	Creek W	√av				21014	1			USA	•
	death	Funerail	11. Marital Status		edent Ever in U	.S. 13.	Was Deced	ent of His			fy Yes or No- can, etc.)	- 1	4. Race - Ameri	can Indian,
S	after or its	3	1 ☐ Never Married 2 ☑ Married	ty⊒Yes If Yes, Giv			iires, spec 1 ☐ Yes 2			rueito Ai	can, etc.)		Black, White, Spec <b>Whit</b> e	
0.0	72 hours after death with the Maryland naturel; or froms 23e or 28e-f show sical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D		3-46								
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$\sim$	othe	BeC	17. Father's Name (First, Middle, Las.	")		1	LDCLU				First, Middle,			VCIIIICIIC
(O F	uld be Mental Irked c	To E	Louis Ricucci						M	liche	lina F	Petro	sino	
Zarv.	2 sho and le mu		19a. Informant's Name/Relationship				•						Town, State, Zip	
	s 1 end 2 should be file I Health and Mental Hyg Item 27 le marked othe other traumatic event,		Margaret Marie R	icucci/		1005			g Cree	k Wa	y, Bel		, MD 21	
	00-		20a. Method of Disposition  1 Burial 2 Cremation 3		State Dood	emetery, creations Men	matory or ot	her place	) Fe	b.	13,		ation - City or To	
DO_	permit. Pag Department Important: eny Injury c		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		nt Farm				of Facility	200	17			Maryland
₹ a	Depa Impo eny l		1 9/1/1/2	RI	0	4.0							e Inc.	g, MD 20901
7 4	8 8	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each five.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
007617 P.O. Box 68	the death cert y the attendin Iched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□ Unkno	irth 2 ☐ Feta ant at time of d own	if death 3	Ectopic pre	ecify)	- in Read		02- Didu		3d. Date of delive	Day Year
S S	signe bed	٥	Part II. Other significant conditions		r.I.	Red	nderiying ca		mari	M	236. Did to		No 3 □ Prot	he cause of death?
ecor	The law requires that te has been signed b age 2 should be deta	Completed	Canto	rosta			<i>}</i>	8			24a. Was autop	an	24b. Were auto	opsy findings available impletion of cause of
0 00		Con	7								perfor	rmed?	death?	219 No
II #	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:				Othe	-		Check only o			
0	ding Phys	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date (		ER/Outpatier 28b. Time of		Bc. Injury	4 🗆 IAUIS		d. Describe h		Other (Specif	(y)
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	H	Certification:	3 Suicide 6 Could not to	286. Place	of Injury - At h	ome, farm, str	eet, factory,	office		28			Number or Rura	al Route Number,
ري ق	rs efter rs efter ra Dir	Cer		Dalidi	ng, etc. (Opacii	y) 					City or Tow	ni, State)		
Œ	To the Hospital or At within 24 hours efter of To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one)  Certifying P  Certifying P	hysician: To the miner: On the ba and mann	best of my kno asis of examina ner stated.	wiedge, deatl ition and/or in	n occurred a vestigation,	it the time in my op	e, date and i inion, death	place, and occurred	d due to the a at the time, o	ause(s) a date and p	and manner as solace, and due to	tated. the cause(s)
	To the complete	Σ	29b. Signature and title of certifier	Atte	ndr	ing		License	P4 (	44		11	signed (Month,	Day, Year) The 2 טט
_	,		30. Name and address of person who	IR HIS	e of death (Item	n 23a) (Tyoe, <b>2</b> S.	Print) Aヤレ	100	d R	oad		el	aing	1014
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 2 20	107	egistrar's Signa	ture	N.							

			For	State of Marylan				Mental Hy	/giene	4000	
			1 - State Registrative No. 12/1	3/07, BMW, McCo	Cei	tificate of	Death		Reg. No.	2007	06143
	Physici		1. Decedent's Name (First, Middle, Last)	Reuben				2. Date of Do Month Februa	Dav	Year	3. Time of Death 11:45 P M
	/Medio Examin		4a. Facility Name (If not institution, give st Renaissance Gardens			4b. City, Town, o	or Location of Dea			, 2007 County of Death	11:45 F
	Examin	CI	Renaissance Gardens	Nursıng Home <b>H</b>	9		r Spring			ontgomer	• \$77
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi		9. Birthr	place (State or Foreign
	Director		375-16-2665 <sup>1</sup>	M 2□F 8	7 Yrs.	Months Days	Hours Mi	Dec.9,	1919	Virg	inia
	pu ,		Usual Residence of Decedent	40. 00	. T						
	arylar show	_	10a. State 10b. County	10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Ra-f	Director	Md. Montgomery	7 Si	lver	Spring					1 ☐ Yes 2 反 No
	vith the	Ë	10e. Street and Number			10f. Zip Code				zen of What Cour	ntry?
	s 23s	eral	3124 Gracefield	Rd.	0 140 1		904	(Dana 16 , Van and 1		S.A. 14. Race - Americ	on Indian
	ltem Item	Funeral	11. Marital Status 1  1 □ Never Married 🏞 Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1x Yes 2 No 194</li> </ol>	2_   13. \	Vas Decedent of H f Yes, specify Cub	an, Mexican, Pu	(Specify Yes of Ni erto Rican, etc.)	0-	Black, White,	
3	rs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 194	_   .	I ☐ Yes 2 № No	Specify:			Specify: Whit	A
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	bed	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	pation			nd of Business/In	
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7	d with	ĕ	Ziomoniary, occorriaary (o 12)	5+	A.I.	D. Person	nnel Man	agement	U.S.	.Governm	ent
9	e file al Hy othe	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden	Surname)	
<u>a</u>	ould b Ment arked atic e	P	Isaac Reuben				Bertha				
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Typ		1	g Address (Street					
≥ ~``	and lealth m 27 her tr		Ethel Reuben (Wife			Gracefie:	ld Rd.#4			457	
0	ges 1 t of H If itel or otl		20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Re		lace of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or To	own, State
Ē	. Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)	Cha		Cremator	_	.10,2007			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License		Ch	Name and Addre	ess of Facility uneral I	Home & Ci	emat	orium, P	.A.
	w o		(3)	cimh-		01 Cleve				Md. 207	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the deatr e cause on each line.	n. Do not ent	er the mode of dyi	ng, such as cardi	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Parkinson		e				Y	ears
	/Medical Examiner		1	Due to (or as a consequ	uence of):						
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
	rted nsit	Examine	cause. Enter Underlying Cause (Disease or Injury) that initiated events	(							
,	execution and all-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
8/60,	death certificate be executed e attending physician and id for use as the burial-transit	dical									
2	ificate g phy as the	edic	J								
gox	that the death certificated by the attending produced for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregna	ncy	le			2	3d. Date of delive	ery
	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal		]Ectopic pregnanc ] Other <i>(specify)</i> _	y 			Month	Day Year
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	8 5 8	by P	Part II. Other significant conditions cont		-		ven in Part I.	23e. Did	tobacco us	se contribute to the	ne cause of death?
Hecords,	w require been sle should b	ed	Chronic Obstructi	ive Pulmanary	Disea	se		- 10	Yes 2	No 3□ Prob	ably 4 Unknown
ပ္ထ	law r as be 2 sh	Completed						24a. Was		24b. Were auto	psy findings available mpletion of cause of
	The ate has page	Jom							ormed?	death?	2 □ No
Vital	slcian: The law certificate has l irector, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of D	eath Check onl			
<u>o</u>	Physician: r this certifica ral director, I	10	1 Yes 2 No		ER/Outpatien	t 3□ DOA Oth	ner: 4 Nursing	Home 5 ☐ Res	idence 6	☐Other (Specif	y)
	fell fell	:io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury	occurred /	
Si0	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 ☐ No				
UIVISION	or At fter d Direct in by	Certification:	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stro /)	eet, factory, office		28f. Location (	(Street and wn, State)	d Number or Rura	l Route Number,
_	pital urs a eral [		One Certifies 1 Certificing Phys	inform To the best of my less				28			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A _completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examinated and manner stated.	wieuge, death tion and/or in	restigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time	cause(s) , date and	and manner as si place, and due to	tated. the cause(s)
	o the ithin o the omple	Mec	29b. Signature and title of certifier	/ mainer stated.		29c. Licens	se number		29d. Date	e signed (Month,	Dav, Year)
	FSFO			-4			4035			uary 9,	
,	121		30. Name and address of person who cor	moleted cause of death (Item	23a) (Tuna		+000		repri	lary 9,	2007
			Eugenio S. Machad				Silver	Spring	Md. 3	20904	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signal	ture		20	-F 9		-0704	
	Registi		FEB 1 3 2007	A. A.	do	. 49 .					

DHMH 17 Rev 1/2001

			For State Registr <i>a</i> r	State of Marylar		artment of rtificate of		_	giene Reg. No. 0	7 06144	
			Decedent's Name (First, Middle)	Last)		<u> </u>		2. Date of De		3. Time of Death	
	Physicia /Medic		Abul B.	Rahman				Februa	ary 9,20	007 1:09 PM	
	Examin	er	4a. Facility Name (If not institution		-	_	or Location of Dea	ath	4c. County o		
	F		Laurel Reg 5. Social Security Number	ional Hospita  6. Sex 7. Age (In yrs.		Laur If Under 1 Yea	r If Under 24 Hr			9. Birthplace (State or Foreign Country)	
l.	Funeral Director	j.	218-15-7539	1⊠M 2□F 80	Yrs.	Months Day	s Hours Mii	Jan. 1	19, Year)	Bangladesh	
Special	P ,		Usual Residence of Decedent	10c Ci	ity, Town or Lo	neation				10d. Inside City Limits	
	anylar show	'n	Md. 10b. County		aurel	Joanon				1 ☐ Yes 2 🛣 No	
	the M	recti	10e. Street and Number	2 0001902   20		10f. Zip Code			10g. Citizen of W	hat Country?	
	3a or	Ē	14003 A Just	in Ave.		2070	7		U.S.A	•	
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of	f Hisp <i>a</i> nic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race Black	- American Indian,	
9	or ite	y Fu	1 ☐ Never Married 2 ☑ Marri	ed 1 ☐ Yes 2 No		1 ☐ Yes 2 <b>X</b> N				Asian	
21215-0036	hours tural", al Exa	ed by	3 Widowed 4 Divorced	Year or Dates:	16a. Dece	dent's Usual Occ	upation		16b. Kind of Bus		
7	in 72 n "nai	plete	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5+)	(Give	kind of work dor DO NOT use reti	ne during most of w red)	orking		•	
212	d with giene	Completed	Elementary/Secondary (0-12)	5+	uner	nployed	T		none		
	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Moulana Hab:						, Maiden Surname		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	2			10h Maili	na Address (Stra		Habibur	III1SSa per, City or Town, S	Rahman	
Mar	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relations Anis Rahman						•	a. 20707	
	Health Health tem 27 I		20a. Method of Disposition	20b.	Place of Disp	osition (Name of ematory or other p	i	Date		City or Town, State	
m 0	Pages ent of nt: If 1		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from State Man	ryland	Natio	nal 2/	11/07	Laurel	, Md.	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Simpur of Funeral S						al Mort	_	
0	o a E c		11 aus	are						ton, DC 20011	
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused the dea only one cause on each line.			lying, such as card	iac or respiratory a	arrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. BILATERAI  Due to (or as a conse		EUMONIA					
	Examiner			INFLUENZA		INFECT	ION			10 days	
	FIELD	ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	Sucree off:			<del></del>			
3760,	be execian a	Ē	resulting in death, Edec	Due to (or as a conse	equence or).						
687	physi	dical		d							
Box (	certif nding use as	Completed by Physician/Med	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome pf pregr					23d. Date	e of delivery	
	death e atter	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fei		□Ectopic pregna □ Other <i>(specify,</i>			Mor	nth Day Year	
P.0	at the by the tache	hys	9 Unknown	9□Unknown						the state of the state of	
	requires that the een signed by the nould be detache	by F	_	ons contributing to death but not re		underlying cause	given in Part I.			ibute to the cause of death?  3  Probably 4 Munknown	
oro	requi	sted			<u> </u>			_			
<b>3ec</b>	sician: The law certificate has birector, page 2 s	mple		FFICIENCY				24a. Was - auto peri	opsv p	Vere autopsy findings available prior to completion of cause of leath?	
<u></u>	n: Th ficate or, pa(		ANEMIA 25. Was case referred to medica	1			26 Place of F	1□ Yes Death (Check only		☐Yes 2☐No	
₹	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 X Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Other:		sidence 6 Othe	er (Specify)	
0	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. In	njury at Vork?	28d. Describe	how injury occurre	ed	
Sio	ttending Jeath. stor: After	atio	2 Accident investi	gation			☐ Yes 2 ☐ No				
Division or Vital Records,	or Att fter de Sirect in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		home, farm, s cify)	treet, f <i>a</i> ctory, offi	ce		(Street and Number own, State)	er or Rural Route Number,	
	pitat ours a eral [	Se	29a, Certifier 1 X Certifyli	ng Physician: To the best of my kr	nowiedge, dea	ath occurred at the	e time, date and pl	ace, and due to the	e cause(s) and ma	nner as stated.	
	To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical one)	Examiner: On the basis of examinand manner stated.	nation and/or	nvestigation, in n	ny opinion, death o	ccurred at the time	e, date and place, a	and due to the cause(s)	
_	To th within To th comp	Me	29b. Signature and title of certified				ense number			i (Month, Day, Year)	
	ł		) Cll	alle	MD		0649		219		
_	•			who completed cause of death (Ite				_	l Hospi	tal.	
		ato	Chike G.  31. Date filed (Month, Day, Year FEB 13	Onwuka 7300	van Di	4	. Laure	I, Md.	20/07		
	St Regist	ate	FEB 13	2007 32 Registrar's Sign	KA	south)					

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Stem

MD

32. Registrar's Signature

7-00976 lary A. Rawlings		Please Type or Print in Black Indelible Ink. Ensure All Copie		jible.	
iary A. Rawiiigs		State of Maryland / Department of Health and Mental H For State Certificate of Death	_	200	7 06146
Physician		gistrar Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
/ledical Examine	er	Mary A. Rawlings	Month February 5	Day Year , 2007	0510 hrs
	48	. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Mercy Hospital  Baltimore		4c. County of Dea	ath
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8 Date of Birti	N/A	Birthplace (State or
Director		217-40-7735 1 M 2 X F 65 Yrs. Months Days Hours Min	_	For	eign Coun <b>M</b> aryland
	_	sual Residence of Decedent	11-		
v any		la. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 X Yes 2 No
Maryland 28a-f show any d at once.	o Ma	aryland Anne Arundel Annapolis	Tao	- Ohi of With the Co	
or 28a	21	De. Street and Number 10f. Zip Code	100	lg. Citizen of What Co USA	ountry ?
with the Maryland ms 23a or 28a-f sho be notified at once		707 Newtown Dr. Apt H 21403  Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Si	pecify Yes or No-		erican Indian, Black,
leath v	<b>=</b> 1	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	
after of al", of inter n		Widowed 4 Divorced of Yes, Give Year or Dates:			lack ———————
hours Fram	<u></u>	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		16b. Kind of Busines	s/Industry
136 hin 72 e. than *	<u>e</u>	11th 0 Domestic		Private	Family
215-0036 be filed within 72 hours after death with the Maryland ntal Hygicine. rked other than "natural", or items 22s or 28s-f she cit. the Medical Examiner must be notified at once	Completed by	7. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M	laiden Surname)	
21215-0036 Duld be filed within 7 Mental Hygiene. Imarked other than ic event, the Medica	8 <u></u>	Judicite Rentalia	A. Har		
e, MD 21215-003i  I and 2 should be filed within Health and Mental Frgiene, item 27 is marked other the r transmitter event, the Medi	- 1	Dea Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Donath Vilson (Daughter)  707 Newtown Dr. Archive.		-	
re, MD Hand 2 sho Health and Fitem 27 is		Ophelia Wilson(Daughter) 707 Newtown Dr. And Daughter)  Ja. Method of Disposition 20b. Pracetof Disposition (Name of cemetery, crematory of other place)	Date	20c. Location - City	or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic.		Memorial Gardens   2-	13-07	Annapoli	s, Md.
altin nit. P. Partme oortan ny or		Donation 5 Other Specify:  1. Signature of Funeral Service Licensee  22-Name and Address of Facility WM. Reese & Son	s Mort	nary. P.	Α.
Per Dep Tiliji		Lavy J. Reese MOOF 3   821 West St. Ar Ba. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	napoli	s. Md. 2	1401
Physician	2	Ba. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Between Onset and
/Medical Examiner		nmediate Cause (Final disease r condition resulting in death)  a Complications Of Head Injuries  Due to (or as a consequence of):			Death
	1	h			
	ner e	equentially list conditions, any, leading to immediate Due to (or as a consequence of):  ause. Enter Underlying Cause			
	E (	Disease or injury that initiated vents resulting in death) Last Use to (or as a consequence of):			
iox 68760, leath certificate be executed a strending physician and for use as the burial - transis	ica  -	d			
O, the expectation solution ourisity		UNPENDED AMENDED		23d. Date of deliv	
876 tificate ng phy as the i		FEMALE: b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregn	ancy	Month Month	Day Year
ox 6	Sicia	4 Pregnant at time of death 5 Other (Specify)			
b. BC the dea	골	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
P.C ss that gened to deta			1 Yes	2 <b>✓</b> No 3 □ P	robably 4 Unknown
rds, requir	etec		24a. Was a		autopsy findings available o completion of cause of
e law te has	Completed by		perfor	med? death	
al Rount III	ပ္ကို - ရွိ	5. Was case referred to medical 26.Place of Death (Check	only one)		
Vita hysici this co	오ㄴ	1 V Yes 2 No			ner:
n of ding P After funera		7. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending Dec 30, 2006 1 1 Yes 2 ✓ No		now injury occurred auto auto collisio	n
Siol Atten r death ector: ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm street, factory, office building, etc.	28f. Location (S	Street and Number or	Rural Route Number, City
Divi	린	Suicide 6 Could not be determined (Specify) Local Street	or Town, S Jennifer Road	tate)	Annapolis, Md.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	S S	9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the caus	e(s) and manner as s	tated.
Fo the vithin Fo the comple	٦L	nee) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to	
	Σ 2	9b. Signature and title of certifier  29c. License number  O.C.M.E.		February 6, 20	
		0. Name and a few of person who completed cause of death (item 23a)			
2	13	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
	ate 3	11. Date filed (Month, Day Year) Registrar's Signature FEB 1 2 2007			
Registi	rar				
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				1 - For Registrar	State of	Marylar	•	rtment o			Mental Hyg	iene	07	06147
				Decedent's Name (First, Middle, Last)							2. Date of Deat	h		3. Time of Death
		Physici /Medio		DAVID UPTON	STANG						Month FEBRUAR	Day 782	Year 007	18:00 M
		Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or Loc	ation of Death		4c. County	of Death	
				Homewood at Cruml						lerick		Fre	deri	
		Funeral Director		5. Social Security Number 6. Sec. 217-07-7949	M 2□F	'. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Oct. 4	Year) 1918	9. Birth Cou Ma	place (State or Foreign intry) aryland
		p .		Usuel Residence of Decedent  10a, State 10b, County		10c C	ity, Town or Lo	action						10d. Inside City Limits
		ehow	ក	Md. Howard		100.0	Mount							1 Yes 2 No
		28a-1	ect	10e. Street and Number				10f. Zip Co	nde.		110	0g. Citizen of \	What Cou	
		ith with the Maryla 23a or 28a-f ehov	ā	1144 Ridge Road				101. 210 00		21771				States
		death ms 2;	Funeral Director	11. Marital Status	12. Was Deced	tent Ever in U	J.S. 13. V	Vas Deceden	t of Hispar	nic Origin? (Sp	ecify Yes or No-	14. Rac	e - Ameri	can Indian,
8	9	or Ite		1 Never Married 2 Married	Armed Ford 1 Keyes 2 If Yes, Give	2 □ No		Yes, specify □ Yes 2 🗷		exican, Puento pecify:	Hican, etc.)		k, White	
00	5-0036	72 hours after dea "neturel", or Items idical Examination	d by	3 M Widowed 4 □ Divorced	Year or Dat	tes: WW.	T T	105 215	LINO SE	occiry.		Specify	·. •	White
008180	5-(	filed within 72 hours after death with the Maryland Hygiene. wher then "neturel", or Items 23a or 28e-f ehow whit, the Medical Examirye must be notified at	Completed	15. Decedent's Edu (Specify only highest grade			(Give	lent's Usual C kind of work of OO NOT use r	done during	g most of work	ang	16b. Kind of Bi	usiness/Ir	ndustry
9	2121	withir iene. then	dmo	Elementary/Secondary (0-12)	College (1-4	4or 5+)		mber	emea)			P.	Lumb	ing
F	9	be filed within 72 hours after dea ital Hygiene. Ind other then "neturel", or Items event, i've Medical Examiner on	Be Cc	17. Father's Name (First, Middle, Last)					18.	Mother's Nam	e (First, Middle, N	Maiden Suman	16)	
1	<u>lan</u>	vid be Aentai rked o	To B	Paul Louis S	tang					Ethel	Mae	Small		
7	Maryland	s 1 and 2 should be filed w f Health and Mental Hygie Item 27 le marked other to other treumatic event, In	. y.	19a. Informant's Name/Relationship (Ty	-			-			al Route Number,			
5	2	and ealth m 27		Brenda S. Unglesh	ee/Daug			4 Ridg		-	unt Airy			21771
8	Baltimore,	it of H it of H if Ite or oth		20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ R	emoval from S	tate	Place of Dispo cemetery, cren	natory or othe	r place)			20c. Location -		
00	Ę	rtmen rtmen rtent: njury		4 Donation 5 Other (Specify)		Ne	elsvil				3/07	Neels	71116	e, Ma.
poposals los	Ba	permit. Pages 1 and 2 Depertment of Health a importent: If Item 27 is eny injury or other tre once.		21. Signature of Funeral Service License  Thurstell IV	Barl	her	22	Murie P. O.	1 H.	Barber 5038	Funeral Laytons	Home ville.	Md.	20882
D				23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that can	used the dea ch line.	th. Do not ente							Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	End	Stage	l Dema	tre.						Onset and Death
0		/Medical Examiner		resulting in death)		r as a conse	4							7.7
30		Cxammer	J.	Sequentially list conditions,	dan		Cent:	>12						22 2000
ge	>	bed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Liberton	as a conse							1	> 10
3		icate be executed physicien and s the burial-transit	xar	that initiated events resulting in death) Last	Due	r as a consec	quence of):						-	in divini
5	8760,	e be sicier	dicai E											
9	9	tificat ig phy as th	Φ											
-3	Box	leath certific attending pi I for use as t	an/N	230. Was decedent pregnant	3c. If yes, outco	ome of pregn th 2 Pet		Ectopic pregr	nancv				e of deliv	
David	O. E	ne dea the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nt at time of		Other (special				Mo	nth	Day Year
	من	thet the d ed by the detached		Part II. Other significant conditions con	tributing to dea	ath but not re-	sulting in the ur	derking caus	e awen in	Part I	23e Did tob	acco use cont	ribute to t	he cause of death?
150	ds,	signe d be d	d by	Astron	tributing to dea	atir but not re.	salting in the al	idenying caus	se given in	raiti.		_		bably 4 Unknown
n P	Records,	The law requires thet the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transi	Completed	Calar concer	)						24a. Was ar	24b. 1	Vere auto	posy findings available
R	Re	The lay te hes age 2 :	mo d	Departon.							autopsy perform	led?	death?	opsy findings available ompletion of cause of
0	Vital	ysician: The is certificete hi director, page	Ф	25. Was case referred to medical			·		26.	Place of Deat	1 ☐ Yes 2 th (Check only one		Yes	2L No
N			To B	examiner? 1 ☐ Yes 2 No	ospital: 1 🗆 In	patient 2	ER/Outpatien	t 3 DOA	1		ome 5 Reside		er (Speci	(y)
8	n of	ding Ph h. After th funeral		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe ho			
9	sio	tendir Jeath. tor: Af the fur	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М	1 🗌 Yes	2 🗆 No				
2	Division	l or Attendation death Director:	Certification:	4 Homicide determined	28e. Place of building	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, stre fy)	et, factory, of	ffice		28f. Location (Str City or Town		er or Run	al Route Number,
Known to physician AS8		To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	sician: To the b	pest of my kn	owledge, death	occurred at t	he time, da	ate and place,	and due to the ca	use(s) and ma	nner as s	stated.
Sni		the Hin 24 the Fu	Medical	(Check only 2 Medical Examination)	and manne	sis of examina	ation and/or inv	restigation, in	my opinior	n, death occur	red at the time, da	ite and place,	and due t	o the cause(s)
		With To t	Σ	29b. Signature and title of certifier	Ane. A	0		1	icense nur		29	ed. Date signed	i (Month,	Day, Year)
	7	341		7		_			46:	228		1910	7	
ļ				30. Name and address of person who co					treet	. Fre	derick,	Md. 2	L701	
į.		Sta	te	31. Date filed (Month, Day, Year)		gistrar's Sign				-,				
		Pogiet		FEB 1 2, 200	/ JAN		de de							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** February **ESTHER** STANG 20°07 MILDRED 11:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 X F 83 220-12-9559 Director July 29 1923 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Md. Howard 1 ☐ Yes 2 MNo Mount Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 United States 1144 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No White If Yes, Give Year or Dates: Specify. þ Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fraley Alfred Kinney Dorothy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda S. Unglesbee/Daughter Mount Airy, Maryland 1144 Ridge Road, or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Neelsville Cemetery 2/10/07 Neelsville, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee murie Darker Box 5038, Laytonsville, Md. 20882 P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 01 /Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s las autopsy performed certificate l 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 2 ER/Outpatient 3 DOA Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Defertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no D 16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASPER E. CLINE, M.D. 300 WEST NINTH STREET, FREDERICK, MD. 21701 31. Date filed (Month, Day, Year) FEB 1 2 2007 egistrar's Signature Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.) Certificate of Death 3: Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 8, 2007 Charles Skupsky 3:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) May 1, 1916 5. Social Security Number if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 x M 2 □ F 161-26-7196 Georgia Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ∏Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6111 Montrose Road, # 724 20852 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items, 11 Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. Specify: à 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Clothing 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any linyry or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Skupsky Miriam Valinsky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18274 Rolling Meadow Way, Olney, Maryland 20832 Phyllis Shine - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 2/11/2007 Clarksburg, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (o as a consequence of) 174425 /Medical Examiner hemoptysis Sequentially list conditions, if any, leading to immediate cause in the Unity of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed interstitical distast > c 475 Due to (or as a consequence of): or Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has To the Hospital or Attending Physician: The within 24 hours a 'er death. To the Funeral Director: After this certificate I completely filled in by the fun ral director, pag 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

J. Lawrence 31. Date filed (Month, Day, Year) FEB 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

TENKOVITZ Registrar's Signature

M.D

CHARLES

29c. License number

59267

2101 natical

29d. Date signed (Month, Day, Year)

Silve SAZZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, 2007 6:47 a.M Cleave Ira Shrewsbury February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Unde 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**X** M 2□ F 236-28-8227 West Virginia 83 01/28/1924 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20906 4410 Sigsbee Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify 3 ☐ Widowed 4 ☐ Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator Metro 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) James Edward Shrewsbury Dollie Meadows 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleve I. Shrewsbury-Son 2826 Denley Place, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Parklawn Memorial Pk. 2/10/2007 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Planes-Rinaldi Funeral Home, Inc.
Hines-Rinaldi Funeral Home, Inc.
Hampshire Ave., Silver Spring, MD 20904
Approximate 21. Signature of Funeral Sarvice Ucen ee 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final Amoria Engambalandhu 24 hours 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? given in Part I 1 Tes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or Items 23a or 28a-f show aminer must be notified at

the Medical Examiner

other traumatic event.

item 27 I

Department of Important: If it any injury or o

Director

Completed by Funeral

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

within 24 hours at er death.

To the Funeral Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

resulting in death)	a. Anoxee Encephacopany	24 11000
resulting in death)	Due to (or as a consequence of):	
	Cardiac Arrythmia	
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	
Cause (Disease or injury		
that initiated events resulting in death) Last	C	
	4	
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy	23d. Date of delivery
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Y
9 Unknown	9□Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de
		1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ U
		24a. Was an 24b. Were autopsy findings a
		autopsy prior to completion of ca performed? death?
25. Was case referred to medical	00 Plant (Part)	1 Yes 2 No 1 Yes 2 No
examiner?	26. Place of Death ((	
1 ☐ Yes 2 🛣 No	124 inpatient 2 En/Outpatient 3 DOA   4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year) Injury Work?	. Describe how injury occurred
2 ☐ Accident investigation		
3 Suicide 6 Could not t 4 Homicide deter <i>m</i> ined		Location (Street and Number or Rural Route Numb City or Town, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date and place, and	I due to the cause(s) and manner as stated.
(Check only 2 Medical Exa	miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) FEB 12

29b. Signature and title of certifier

andku LU



29c. License number

Dco 6/937

Sherry Remington Sanchez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0655 hrs **Medical Examiner** February 17, 2007 Sherry Remington Sanchez 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign Country)New York Months Davs Hours Sep. 12, 1957 Director 49 263-94-7691 1 M 2 X F Usual Residence of Decedent 10b. County 10d, Inside City Limits 10a State 10c. City. Town or Location Yes 2 X No Maryland Montgomery Bethesda 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4400 East West Highway Apt. 1112 20814 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married 1 Never Married Yes Specify: White If Yes, Give Year 1 Yes 2 X No specify: Divorced the Medical Examiner is marked other than "natural", ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Veterinarian MD 21215-0036 Medicine Veterinarian Technician 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred A. Brown Be Dovle E. Remington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20814 19a. Informant's Name/Relationship (Type, Print ) 4400 East West Highway Apt. 1112, Bethesda, MD Nestor Sanchez / Husband If item 27 Date 24, 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Itimore, Feb. Pages 1 Frederick Brothers tant: 2007 Theresa, New York ent Donation 5 Other Specify Crematory 22 Name and Address of Facility Lawrence Funeral Home 21 Park Street, Canton, 21. Signature of Funeral Service Licensee M00956 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Acute alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical physician a the burial -X UNPENDED AME 32, 27, 28a-f, perME, G865, 3/7/07 TT certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ö ð 1 Yes 2 No 3 Probably 4 V Unknown ے Completed Records, 24b. Were autopsy findings available 24a Was ar autopsy prior to completion of cause of has performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25 Was case referred to medical of Vital Be Other<sub>4</sub> Hospital: DOA Nursing Home 5 Residence 6 Inpatient 2 FR/Outpatient 3 this 1 Yes 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification Natural Yes 2 X No Division Director: I in by the f Pending 2/17/2007 unk. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 or Town, State) 4400 East West Highway Suicide Funeral D determined (Specify) Home ethesda. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Signature and t February 18, 2007 O.C.M.E. 11 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Mooth Registrar's Signatu Day Year State 2007 Registrar

		•	For State Registrar	State of Ma	aryland		rtment of l tificate of	Health and N <i>Death</i>	, ,	iene <sub>eg. No.</sub> 2 (	307	06152
	Physicia	an	1. Decedent's Name (First, Middle, L Charlotte	ast)	Cle		Swa	n	2. Date of Dear Month	h Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, gr	ve street and number)	016			or Location of Death	Februar		2007 ty of Death	13:20P
_	LXaiiiii	CI	Memorial Hospi					berland			Allega	
	Funeral Director		219-14-5365		e (In yrs. Ia 81	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) 03/30/1	Year)	Coui	place (State or Foreign ntry) rland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits
	a-f sh	ctor	MD Alle	egany		Cum	berland					1 X Yes 2 No
	th with the 23a or 28 ust be no	al Director	10e. Street and Number 510 White Av	enue			10f. Zip Code 21	502	1	0g. Citizen of US		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of f Yes, specify Cul I □ Yes 2ሺ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		ace - Americ ack, White,	
Maryland 21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's l (Specify only highest g		i+)	16a. Deced (Give life. L	lent's Usual Occu kind of work done OO NOT use retire	pation during most of worked)	king	16b. Kind of		
2	led wil tygien her th ht, the	Co	1 1  17. Father's Name ( <i>First, Middle, Las</i>	**)		Sa	les Cler		ne (First, Middle, I			Store
and	d be fi ental F ced of c ever	To Be	John	Roscoe		Dor	n	Olive	, ,	.eo	,	Miller
aryi	shoul and Me s mark	ř	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Stree	t and Number or Ru	ral Route Number	, City or Tow	n, State, Zip	Code)
	and 2 lealth m 27 i		Bonnie J. Bish	op / daught		<u> </u>	Hicks Av	renue, Cum			21502	01-1-
nore	ages 1 int of H t; if ite / or ot		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3		ce	metery, crer	natory or other pl	ace) cky Gap O		20c. Location		ne, MD
Baltimore,	permit. P Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		TID							Home, P.A.
8	e a E e		falent C.	alla	e/			tur Stree			MD	21502
V.	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir	ne.		ar man beneve	onary Dis		est,		Approximate Interval Between Onset and Death 10 years
4	/Medical Examiner			Due to (or as	a consequ	ence of):						
1	70 .E	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):						
_	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
8760,	icate be executed physician and s the burial-transit	dical E		d		, 						
Θ		Medi	IF FEMALE:									
Division or Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan Other <i>(specify)</i>	су			ate of deliv	ery Day Year
ds, P.	w requires that I been signed by should be deta	þ	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the u	nderlying cause g	iven in Part I.		bacco use co es 2□ No		he cause of death? pably 4 □Unknown
Reco	he law rec e has beel age 2 shou	Completed	Automatical Control of the Control o						24a. Was a autops perfor	med?	prior to co death?	opsy findings available impletion of cause of
ita	ysician: The sis certificate hadirector, page	Be C	25. Was case referred to medical examiner?					26. Place of Dea	1 Yes ath (Check only or	2 No le)	1 ☐ Yes	2 No
or V	Physician: r this certificaral director, I	은	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 X Inpatie		ER/Outpatier	IL SEI DOA		ome 5 Resid			fy)
on	ding h. Afte fune	tion:	1 Natural 5 Pending 2 Accident investigati	(Month, Da		Injury	W	ork? □Yes 2□No	28d. Describe h	ow injury occi	urrea	
Divisi	₽ # ₽ E	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At hor c. (Specify	me, farm, str	eet, factory, office	)	28f. Location (S City or Tow	treet and Nun n, State)	mber or Run	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the best aminer: On the basis o and manner sta	f examinat							
	To th withir To th	Me	29b. Signature and title of certifier	- ny		-	29c. Licer D33	nse number		9d. Date sign		•
	3		P CO Name and address of	mygh	looth (lt	92a) /T:				Februa	1. À 15	, 2001
	13		30. Name and address of person wh Sunil K. Gu					Cumberla	nd, MD	21502		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 2	2007 32. Registr			backs					

DHMH 17 Rev 1/2001

		-	For State Registrer	State	of Maryl		oartmen e <i>rtificate</i>			and M	ental Hyg	iene g. No.	07	06153
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia Medic		Alda		France	S	Smith-2	Zemb	ower	[]	February		007	2:00 P M
	Examin		4a. Facility Name (If not institution	-					Location of				ty of Death	
			Beverly Living						erlan		a Barra d Blatt		legan	
	Funeral Director		5. Social Security Number 217–42–6383	6. Sex 1 ☐ M 2 ☐ F	7. Age (In	yrs. last birthda Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, 0 1 / 1 4 / 1	Year)	Cou	place (State or Foreign ntry) Vinginia
	D .		Usual Residence of Decedent		10-	. City. Town or	1							10d. Inside City Limits
	arylar show	_	10a. State 10b. County	. m = 10 **	100		rocanon 1berlar	nd						1 ☑ Yes 2 ☐ No
	8e-f	cto		egany							1	0g. Citizen o	f Milhot Cou	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23e or 28e-fehow other traumatic event. It is Medical Examination in conflict at	Funeral Director	10e. Street and Number  1 Baltin	nore Stre	et		10f. Zip	2150	02			-	SA	nuy?
	er deat! Items 2 ner mu	uner	11. Marital Status	Armed F		in U.S. 1	3. Was Deced	dent of Hi city Cuba	ispanic Ori in, Mexican	gin? (Spe 1, Puerto f	cify Yes or No- Rican, etc.)		ace - Ameri lack, White,	
21215-0036	ours afte ral', or I Erami	<u>م</u>	1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	If Yes. G	2 🔀 No live Dates:		1 ☐ Yes	2 <b>∏</b> No	Specify:			Spec	eify: Wi	nite
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7	within ene. than "	hdu	Elementary/Secondary (0-12)		(1-4or 5+)	life	. DO NOT us		•				. ,	7
21	e filed wall Hygier other the	S	12			_	Seci	reta		ar'a Nama	(First, Middle, M		ospita	<u>а</u> Т
Maryland	2 should be fit and Mental H Is marked ott raumatic even	o Be	17. Father's Name (First, Middle, William		yle	Morg	ret			dia		gnes		True
<u></u>	should nd Me mark mati	ပို	19a. Informant's Name/Relations	hip (Type, Print)		19b. M	iling Address	(Street	and Numbe	er or Rura	l Route Number	City or Tow	m, State, Zij	Code)
Z	and 2 : ealth ar n 27 Is ter trau		Maxine G. Sulli	ivan / da	ughter	. 1	318 Cor	rral	Driv	e, Ho	ouston,	TX 7	7090	
Baltimore,	s 1 and 2 of Health item 27 I		20a. Method of Disposition		20	Ob. Place of Di	position (Nar	ne of other place	:0)	D	ate	20c. Location	n - City or To	own, State
E			1 X Burial 2 ☐ Cremation 4 ☐ Donation 6 ☐ Other (S		n State					02/0	9/2007	Cumbe	erland	l, MD
alti	- F F F		21. Signatury of Funeral Service	Licensee										Home, P.A.
m	permil Depar Impor any in		Finet C	allan	2		404 De	ecati	ır Stı	reet,	Cumber	land,	MD 2	21502
	3		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that only one cause on	caused the each line.	death. Do not	enter the mod	de of dryin	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
層	Physician	1.0	Immediate Cause (Final disease or condition	. Co	- char	wood	le	-/	dies	de	4			ulleles
	/Medical Examiner		resulting in death)	Tue t	o (or as a co	nsequence of):		Sec.		10				
	Examiner	'n	Sequentially list conditions,	b. — Due to	o (or as a co	nsequence of):	-				-			
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(0. 20 0.									
	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due t	o (or as a co	nsequence of):								
8760	ate be hysicia the buri			d.										
89	g phy as th	edi	-					-				1		
ŏ	leath certifica attending ph I for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of probirth 2		3 □Ectopic p	regnancy	1				Date of deliv	ery Day Year
.O. B	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pre 9□Uni	gnant at time nown	of death	5 ☐ Other (sp	pecify) _					VIOLITI	Day
4	res that the de signed by the be detached i		Part II. Other significant conditi	ons contributing to	Death but no	ot resulting in th	e underlying o	aluse giv	en in Part I	1.	23e. Did tol	bacco use co	ontribute to I	he cause of death?
ecords,	signe d be	d by	Ocheono	son. (	2	emi	n F	trac	An	ne,	1 □ Ye	es 2 <b>2</b> (40	3 🗆 Pro	bably 4 Unknown
Ö	w require been si should b	ete	2	7							24a. Was a	n 24t	o. Were auto	opsy findings available
Rec	has has	Completed	- of the	June	-						autops	ned?	prior to co death?	ompletion of cause of
a	sician: Th certificate rector, pag	e Co	25. Was case referred to medica	<u> </u>					ne Plane	o of Dogth	1 Yes 2 (Check only on	2 NO	1 🗌 Yes	29-No
Vital	Physician: this certific ral director,	o Be	examiner?  1 Tes 2 No	Hasnital:	Inpatient	2 ER/Outpa	tient 3 DC	Oth		1000000	me 5 ☐ Reside		ther (Speci	fv)
of	y Phys er this eral di	⊢	27. Manner of Death	28a. Dat	e of Injury onth, Day Ye	28b. Tim	e of	28c. Injur Wor	y at		28d. Describe ho			57
ion	Attending F r death. ector: After by the funer	atio	1 Accident 5 Pendi	ng (700) igation	inin, Day 10	<i>ar)</i> Inju	М		Yes 2	No				
Division	l or Attendii after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could 4 Homicide determ	pined 286. Fld	ce of Injury - Iding, etc. (S	At home, farm	street, factor	y, office		1	28f. Location (SI City or Town	treet and Nui n, State)	mber or Rur	al Route Number,
ō	rs after al Dir	Cer												
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	edical	29a. Certifier Certifyi (Check only 2 Medical	ng Physician: To t f Examiner: On the and ma	he best of m basis of exa anner stated.	y knowledge, o imination and/o	eath occurred r investigation	at the tir n, in my c	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ca ed at the time, d	ause(s) and ate and place	manner as s e, and due t	stated. to the cause(s)
	To the within To the	Z.	29b. Signature and title of certific	er /		. (	29	c. Licens	e number		2	9d. Date sign	ned (Month,	Day, Year)
	3		1 / Sul	nota	lh		m)	DOO	544	11		Ebru	my 7.	2007
27			30. Name and address of person										/ /	
	nes		Beverly	Calkins,			Memoria	al A	venue	, Cur	nberland	i, MD	21502	2
	st Regist	ate rar	31. Date filed (Month, Day, Year	8 2007	Registrar's	Signature	Cook	,						

		1	For State Registrar	State of Marylan		artment of H			giene 007	06154
	Physicia	an	1. Decedent's Name (First, Middle, Las Cleatus	Minor		Self		2. Date of Dea Month Februar	Day Year	3. Time of Death 4:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea		4c. County of Dea	
- Q1	K. Austria	X.	Devlin Manor He			Cum	berland		Alleg	
	Funeral Director		5. Social Security Number 6. S 218-16-3996	7. Age (In yrs. i	ast birtnday) Yrs.	Months Days	Hours Mir			nthplace (State or Foreign ountry) yland
. *	,		Usual Residence of Decedent			<u> </u>		007 197 1	JEJ Hai	
	nylan ahow det	_	10a. State 10b. County MD Alle		y, Town or Lo	cation Cumberla	nd			10d. Inside City Limits 1 🖾 Yes 2 🔲 No
	he Ma 18a-f	Director	10e, Street and Number	egany		10f. Zip Code	iiu		10g. Citizen of What C	
	with t	급	621 Maryland A	venue		101. Zip 00de	2 <b>1</b> 502		USA	
9	ges 1 and 2 should be filed within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event. The Madical Examinar must be notified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- orto Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
903	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:						White
21215-0036	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Busines	s/industry
212	f within piene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Во	iler Make	r		Railroa	d
Maryland ;	S should be filed with and Mental Hygiene. is marked other than sumatic svent. In or	To Be C	17. Father's Name (First, Middle, Last) George	Edward	Self		18. Mother's N Lula	ame <i>(First, Middle,</i> Jemi		lson
ary	shou and M s mar	-	19a. Informant's Name/Relationship (			-			er, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Larry A. Self, Sr			Barts Chu	rch Roa	d, Hanove		
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other place	1		20c. Location - City o	
Itim	Pa ned ury		4 Donation 5 Other (Specifical Service Licer			Cemetery 2. Name and Addre	1	2/2007 dams Fami	Flintston	Home, P.A.
Ba	permit. Departr Importe any inje		+ Liket C	Ceclami					rland, MD	21502
AC.	Physician and physician and physician and physician and the printle philar than the philar tha	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	CEREBR	LOV ASC	ULAR F	ACCIDENT	Interval Between Onset and Death  Stranger Stran
.O. Box 68760,	death certifi e attending   ed for use as	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d	Ideath 3	□Ectopic pregnancy	,		23d. Date of d Month	elivery Day Year
rds, P	w requires that the sbeen signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	ınderiying cause gıv	en in Part I.	1	obacco use contribute Yes 2□No 3□F	to the cause of death?  Probably 4 DUnknown
Vital Records,	e iaw r hes bo je 2 sh	Completed							an 24b. Were a prior to death? 2 No 1 Yes	autopsy findings available completion of cause of
/ita	ysician: Th is certificete director, pag	Be (	25. Was case referred to medical examiner?	Manadali		04		eath (Check only o	one)	
of	hya this aldi	2	1 Yes 2 No		ER/Outpatie	nt 3 DOA Oth	47 140151119		dence 6 Other (Sp	ecity)
o	en en	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury	Wor	k?` Yes 2□No		many coodings	
Division	or Attendi after death. Director: A in by the t	Certification:	3 Suicide 6 Could not be determined	OB Bloom of Injury At h	ome, farm, s fy)	reet, factory, office		28f. Location ( City or To	Street and Number or I wn, State)	Rural Route Number,
luqui	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.						
	within 2 To the comple	Me	29b. Signature and title of certifier	2 : 1/		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
						Γ	0023371		February	9, 2007
-	67		30. Name and address of person who Qamar U. Za:			Print) Avenue,	Cumberl	and, MD	21502	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 2	32. Registrar's Signa		Cools				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0721 AM Feb 12 2007 **Physician** Speciale Linda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Memorial Hospital Calvert Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1□ M 2□ F Months Days Hours Min April 217-52-1799 4 1949 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Calvert Lusby 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1319 Bucks Lane 20657 United States Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) receptionist Beaches Water COOP 12 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loraine A. Isner Mervin Brown Delawder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James R. Speciale -husband 1319 Bucks Lane Lusby Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Funeral Service Alexandria Virginia 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home P.O. Box 600 Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) year Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifie 043306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ID Sylvia Bongers Batong, MD 11845 H. G. Trueman Road, Lusby, Maryland 20657 31. Date filed (Month, Day, Year) 32. Registra Signature State 2007 ROBLARY FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- Registrar

For Amend ed #1,17818 State of Manyland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Raymond B. Smith Raymond B. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 66 1 15 M 2 □ F 215-14-7598 9/2/40 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X Yes 2 No Md. P.G. Largo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 U.S.A. 600 Largo Road death \ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 XNever Married 2 Married African-Salfimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled None 12th 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th ther traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Brown Margaret Brown William A. Smith William A. Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains 4202 58th Ave., # 124, Bladensburg, Md. Lillian Wallace/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 2/17/07 Resurrection Cem. Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee y aury Dall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsaase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown eum Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform certificate 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) 1 Yes 2 1No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 /npatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MUD53718 07 90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hansson

31. Date filed (Month, Day, Year) FEB 14 2007

DHMH 17 Rev 1/2001

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Lachan, Mb.

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

oleted cause of death (Item 23a) (Type, Print)

. 3233 SUPERIVE

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day \_ Month Taylor 10:20 AM **Physician** Anna Mary February 8, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany & Ext. Care Cumberland Lions Center for Rehab. if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/14/1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Min 1 ☐ M 2 🛛 F 90 Maryland 217-10-4213 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No Cumberland MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21502 526 Avondale Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 21215-0036 White Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Minta Marie Davis 0. Atkinson Clarence 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3581 Weems Road, Weems, VA Susan T. Haydon / daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Park |02/11/2007 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatury f Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD Kelet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 01100 Liean Physician /Medical Due to (or as a consequence Examiner Cardiomyopaly nknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to (or as a consequenc Physician/Medical Examiner law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has l autopsy perform After this certificate funeral director, pag Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner: 1 ☐ Yes 2 X No Other: Nursing Home 5 - Residence 6 - Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 39. Name a Suite #102 Cumberland, 1025 Kent Mimao 31. Date filed (Month, Day, 32. Registrar's Signature Year) State FEB 1 2 2007 Registrar

DHMH 17 Rev 1/2001

<sup>D</sup>2, 2007

2:35 A

Month

February

**Physician** /Medical Examiner

1 - For State Registrar

James Dillard Turner, Jr.

Funeral Director

the Maryland d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any Injury or other traumatic event

3altimore, Maryland 21215-0036

**Physician** /Medical Examiner

attending physician and for use as the burial-tran P.O. Box 68760, ned by the a detached f Division or Vital Records, 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Hospital or Attending I

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2□F Yrs. 220-28-5495 73 Aug. 19, 1933 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits Prince George's Hillcrest Heights 1 ☐ Yes 2 X No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 US 2340 Jameson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: چ Specify. White 3 ☐ Widowed 4 💢 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Brick Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Lee Meadows James Dillard Turner, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6535 James Lee Drive, Hughesville, MD 20637 19a. Informant's Name/Relationship (Type. Print) Sharon L. Guertin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD 2-13-2007 22. Name and Address of Facility 21. Signature of Euneral Service Licensee 3035 Old Washington Road M01391 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encephalopat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 12, 2007

DHMH 17 Rev 1/2001

State Registrar

To the I within 2

Manesh Nachnani, MD, 7503 Surratts Road, Clinton, MD 20735

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Februari Volar **Physician** Vell 2007 1323PM 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospi timore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 M 2 F Director May 25, 1935 Finland 214-32-3847 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits a or 28a-f show t be notified at 10b. County MD 1 Yes 2 No Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be none. 600 Poole Road 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salme M. Volar Mihkel Binsol 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann King/friend 2018 Walsh Drv Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery 2/12/2007 Westminster, MD 21. Signature of Funeral Service Licens Pritasafulleralia Home and Chapel, P.A. 412 Washington Rd Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute lenkemia Immediate Cause (Final disease or condition resulting in death) b ast **Physician** days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for he a consiquence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Munknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number WIL Name and address of person who completed causerof death (Item 23a) (Type, Print) Trafi Desai . The Johns Hopkins Hospital, 600 N. Wolfe St. Baltimore 6

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0 7 Day 02 2007 Johnnie Wooten Jr 12:20ph 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/04/29 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 **X**M 2 □ F 77 Lagrange, NC 246-54-3758

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural," or items 23s or 28e-f show any injury or other traumatic event, the Madical Examinar must be inclified at once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Usual Hesidence o	Decedent									1	
10a. State	10b. County		10c. City, Tov							10d. Inside City L	
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10e. Street and Nu 4224 1	omber 3th Plac	ce N.E.			10f. Zip Code 200	17		10g. Ci	tizen of What C	Country?	
11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces?		13. W	as Decedent of h Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Am Black, Wh		
3 ⊠ Widowed		If Yes, Give Year or Dates:		1	☐ Yes 2 🛣 No	Specify:			Specify: B	lack	
	15. Decedent's Ed	de completed)		(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of v	working		Gind of Busines: deral	s/Industry Governs	m 🛆 t
Elementary/Seco		College (1-4or 5	5+)	Par	ramedic						
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	•	Removal from State	cemete	ery, crem. ony	ition (Name of atory or other pla Memori	al $\frac{2}{}$	,	Lan	ocation - City o	Md	
21. Signature of F	uneral Service Licer	nsee 2		5 7	Name and Addre	ess of Facility S rgia A	nead Fu ve NW W	ner Iash	al Hom ington	e & Cren ,DC 200	mat 11
Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to a cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediate erlying r injury	b. Due to (o. as	a consequence	a Ul).	ilr.	brovi	KS CULI		ACG	Onset and Dea	
IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	у			23d. Date of d Month	elivery Day Year	ir
Part II. Other sign	ificant conditions	contributing to death b	out not resulting	in the un	derlying cause gi	ven in Part I.	· Oh	tobacco		to the cause of death	
25. Was case re e	10 CGV	10 pert	115	d	ehyo	26. Place of I	24a. Wa auti per 1 Ves	opsy formed? 20 N	death's		ilable ie of
examiner? 1  Yes 2 2 27. Mannier of Des	th 5 Pending	Hospital: 1 Ninpatio 28a. Dale of Inju (Month, Da	ient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence ury 28b. Time of 28c. Injury at 28d. Describe how						pecify)		
2 Accident 3 Suicide 4 Homicide	investigatio 6  Could not be determined	28e. Place of In	jury - At home, tc. (Specify)	larm, stre		,	28f. Location City or To			Rural Route Number	,
29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	of examination a								
29b. Signature an	d title of certifier	(i)	1.0		29c. Licen	se number	71	29d. D	ate signed (Mor	nth Day, Year)	111

State Registrar Washington Adventit Hosp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Walker Demetrius HNTHONY 0722AM 2007 ebruary 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hospital Hageistown Washington Washington 8. Date of Birth (Month, Day, Jan. 18 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 418-04-0324 Year) 1 Ø M 2 □ F Days Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Washington Md. Hagevstown 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Drive 13818 theuson U.S. A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Icle communications Elementary/Secondary (0-12) ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clittord Golden Walker Shirley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) tulerson Drive - Hagerstown Md. 21740 telicia Walker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☑Burial 2 ☐Cremation 3 ☐Removal from State MAIN POST COM. FLOB. 23, 2007 FORT BENNING GEORGIA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Line 22. Name and Address of Facility GARY L. ROLLINS FUNERLITOME Jun d. 21701 FREDBRICK MD 110 WEST SOUTH ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Minutes Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2[XNo 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform lyceni 2 X 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b Time of 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

burial-trar

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

Division or Vital Records, P.O.

Physician

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

Physician/Medical Examiner IF FEMALE: Certification: To Be Completed by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of Death Natural
Accident 5 Pending

(Month, Day Year)

28c. Injury at Work?

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

OPACCOURT, HAGERS TOWN, MD 21740 31. Date filed (Month, Day, Year)

State Registrar

1 5 2007

investigation

determined

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

after death.

To the Hospital of within 24 hours aft To the Funeral D completely filled in

filled in by

		1 - For State Registrar	State	of Marylar	nd / Depa	artmer	nt of H	lealth a D <i>eath</i>	and M		giene2 Reg. No.	007	06163
Disco-t-		1. Decedent's Name (First, Middle,	Last)		-					2. Date of Dea Month	ath Day	Year	3. Time of Death
Physic /Med		Theo L. Wal	ker			,				Februar	y 9, 20		9:15 a <sup>M</sup>
Exam		4a. Facility Name (If not institution,	give street and n	umber)		4b. City	, Town, or	Location o	f Death		4c. Co	unty of Death	
		Arcola Health & Re				16111-	Silve r 1 Year	er Spri		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Montgom	
Funera Director		217-42-8039	6. Sex 1 ☐ M 2 <b>1</b> ☑ F	7. Age (In yrs. 96	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day March 8,	y, Year)	Cou	place (State or Foreign intry) ict of Columbia
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
death with the Maryland ms 23e or 28e-f show r must be notified at	ō	W 1 1 W			C4	1 C							1 ☐ Yes 2 🛣 No
the tage 28a-	Director	Maryland Montgo	mery		51	lver S	pring p Code				10g. Citizen	of What Cou	intry?
with Sa or		1651 Nordic	Hill Circl	e			209	06			U	.S.A.	
Jeath The 20	Funeral	11, Marital Status	12. Was De	cedent Ever in U	l.S. 13.	Was Dece			gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Ameri	
_ p 22 €	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed F ed 1 Tes If Yes, G Year or	2 to No Sive		1 ☐ Yes		specify:	i, Puerto	Hican, etc.)		Black, White <sup>ecify:</sup> Cau	, etc. ıcasian
2-UU30 72 hours at natural', or		15. Decedent			16a. Dece	dent's Usi	al Occup	ation			16b. Kind	of Business/Ir	ndustry
Kithin 72 Men "na	Completed	(Specify only highest	grade completed		(Give	kind of w DO NOT	ork done d use retired	during most d)	t of work	ing			
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■ \$ \$ ± ±	BeC	17. Father's Name (First, Middle, L		.,				18. Mothe	r's Nam	e (First, Middle,	Maiden Sur	name)	
yiand ould be fill Mental Hi arked oth	To B	George 1	Levy					ŀ	Minni	Rappapor	t		
E OFF	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ing Addres	s (Street	and Numbe	r or Rur	al Route Numbe	r, City or To	wn, State, Zi	p Code)
md 2 sl alth an		Gary Walker	- Son		1651	Nordic	Hi11	Circle	, Si	lver Spri	ng, Mar	yland 2	0906
attimore, mit. Pages 1 au partment of Hea portant: If itsm y injury or othe		20a. Method of Disposition 1   ■ Burial 2 □ Cremation	3 □Removal from	20b. i	Place of Dispo cemetery, cre	osition (Na matory or	me of other plac	(8)		Date	20c. Locati	on - City or T	own, State
battimor permit. Pages Department of Important: If it any injury or o		'4 □Donation 5 □ Other (Sp			g David	Memor	ial Pa	ark 2	2/11/	2007	Falls C	hurch,	Virginia
mit. portr		21. Signature of Funeral Service L	icensee	100				ss of Facility		ome, Inc.			
n ages		Mugh	() . K	lober							er Spri	ng, Mar	yland 20904
Physiciar /Medica		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on	caused the dear each line.  d Stage Mi	itralval		de of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
oertificate be executed certificate be executed continued by the certificate and certificate as the burial-transit certificate as the burial-transit certificates.	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	gurgitatio	quence of)		=						
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that sed by detail	by Pt	Part II. Other significent condition	ns contributing to	death but not res	sutting in the u	underlying	cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ras quires n sign		Hypertension								1 🗆 Y	′es 2□N	lo 3□Pro	bably 4 Dunknown
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	(4)	25. Was case referred to medical						26. Place	of Deat	h (Check only o			
OT VI	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1	Inpatient 2	] ER/Outpatie	int 3 🗆 🗅	OA Oth	er: 4X Nu	rsing Ho	ome 5 Resid	dence 6	Other (Speci	ify)
VISION Of VITA Attending Physician: r death. ector: After this certifice by the funeral director.		27. Manner of Death  1 X Natural 5 Pending 2 Accident investig	9	e of Injury onth, Day Year)	28b. Time o Injury	of M	28c. Injur Wor	yat k? Yes 2 □	No	28d. Describe h	now injury oc	ccurred	
i paritie	Certification:	3 Suicide 6 Could n 4 Homicide determi	200. Fia	ce of Injury - At h	nome, farm, st	treet, facto	ry, office			28f. Location (5 City or Tox		um <i>ber</i> or Rui	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		g Physician: To t Exeminer: On the and ma										
To the Within To the comple	Me	29b. Signature and title of certifier	X		?0	2	c. Licens	e number			29d. Date si	gned (Month	. Dey, Year)
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		Lynne D. Diggs, M	.D., 10400			ue, Sı	ite 2	06, Kei	nsing	ton, Mary	1and 20	895	
S Reĝis	tate	31. Date filed (Month, Day, Year) FEB 1 2	2007	Registrar's Sign	ature	-	,						

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			1 - For State Registrar				cate of L				eg. No.	U/	061	64
			1. Decedent's Name (First, Middle, La	st)						2. Date of Deat Month		Year	3. Time of D	Death
	Physici /Medic			Werner						02	07	07	1355	М
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	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location								
	Aaryla I ehov	ŏ		7. 3.TS <i>T</i>									10d. Inside City 1	
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21215-0036	72 hours after naturel', or ite	ed b	3 Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:		Decedent's	Usual Occupa	ation		1	16b. Kind of		HITE	
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Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Lice	669	5 0		ne and Addres	s of Facilit	У	HOME, P				
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n C	ding P	on:	27. Manner of Death 1 ▲ Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury 28b. Tir a <i>y Year)</i> Inj	me of jury M	28c. Injury Work	rat <br Yes 2∐1		28d. Describe ho	w injury occu	ırred		
isic	death death ctor: y the	ficat	2 Accident investigatio 3 Suicide 6 Could not b		ijury - At home, farr					28f. Location (St.	reet and Nun	ber or Rui	al Route Numbe	e <i>r.</i>
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7	10		30. Name and address of person who		death (Item 23a) (T	VDA Print								
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Registrar

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31. Date filed (Month, Day, Year)

32. Registra

4 2007▶

Rouses

MD 110 Hospital Drive Prince Frederick, MD 20678

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Clarence R. Allen, Jr. Feb 26, 2007 1:55 p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice, Inc. Baltimore 5. Social Security Number 6 Sax If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 10 M 20 F Yrs Director 249-42-1036 78 Mar 16, 1928 So. Carolina Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Mudical Examiner must be notified at Director Maryland N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 Mt. Holly Street or items 23s 21229 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married 1 ▼Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Skilled Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence R. Allen Sr. Eda Chesnut ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Allen 222 Mt. Holly Street Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 03/05/07 Owings Mills, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Iremia MKnown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 TUnknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Onknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed: certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medicai Certification; 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral pelli the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely i 29b. Signature and tiple of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Entawst Baltimore MD Hospice State MAR 0 1 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh 9865 3-1-07 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Bornes Michael February 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** -48-042 Months Days 1**/2**M 2□ F 53 03 n.c Director - 29-145 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the M-dical Examiner must be notified at 10d. Inside City Limits 1**Z**İYes 2 ☐ No Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2/2/ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 27 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: BIACH Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "na any injury or other traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) RINTER BIVE PRINT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE EliZABEth ပ 19a. Informant's Name/Relationship (Type. Print) ORV6 n 1 ER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARNES 1632 UniVERSity LANDAI 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAltiMORE 3/7/2007 21. Signature of Funeral Service Licensee

6 hulf AWEAThER foro BA 110 MB 21213 22. Name and Address of Facility AWEATHER FORD FS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** sepsis /Medical Due to (or as a consequence of): Examiner gram regative rod Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bacteremio Examine death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate has page 2 s 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient ဥ 2 ER/Outpatient 3 DOA After this funeral To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Februaru 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer M. Coughlia, HD 4940 Eastern Avenue Baltimore, MD 21224

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 0 1 2007

07-01564 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert A. Brazell, Jr. 1- For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day February 25, 2007 Brazell, Jr. 1520 hrs Allen Medical Examiner Robert 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** oreign Months Director Apr. 12, 1988 18 212-31-5858 1X M 2 F Country) Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 XNo Ellicott City 28a-f shov MD Howard Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21043 3105 Wheaton Way Apt. J 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes White Yes 2 No specify 4 Divorced If Yes, Give Year Specify 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Education 10 Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brazell Allen Brazzel, Sr. Leslie Anne Naumann Be Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert A. Brazzel, (Father) 114 Palmetto Drive, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crestlawn Mem. Gardens 3/5/2007 Marriottsville, MD permit. Pages
Department or
Important: I 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 Brian L 400769 23a. Part I. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Blunt Force Injuries of the Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Examine Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - trans Physician/Medical x AMENDED item/17,19a,perFH,G865,3/5/07,WS UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? o þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be Other<sub>4</sub> Hospital: 1 V Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 🗸 Yes မှ 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day Year) Feb 24, 2007 28b. Time of Injury 27. Manner of Death Certification: Subject beaten 0030 hrs Natural 1 Yes 2 🗸 No 5 Pending 24 hours after death. Funeral Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 6 Could not be Suicide or Town, State) 9440 Old Frederick Road, Ellicott City, MD determined (Specify) Parking Lot 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie February 28, 2007 O.C.M.E who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

ORIGINAL

		1 = For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artmen <i>rtificati</i>	t of Health e of Deal	h and N th	Mental I	Hygie Reg.	lice C	7	06169
		Decedent's Name (First, Middle,	Last)						2. Date o		Davi	V	3. Time of Death
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		Summit Park Nurs	ing & Re	ehab Ce	nter	Cato	nsville				Balti	more	
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		Usual Residence of Decedent											
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should ind Men marke	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street and Nui	mber or Rui	al Route N	umber, Ci	ity or Town,	State, Zip	Code)
		Nancy Morsberge	r/Daught	er	2810	Illir	nois Ave	Hale	thorp	e, M	2122	2.7	
s 1 and if Healt Item 2 other		20a. Method of Disposition			b. Place of Dispo	osition (Nar	me of other place)		Date	200	. Location -	City or To	own, State
permit. Pages 1 ar Department of Hea Important: If Item any injury or other once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	letro Cr			. 2/28	3/07	Ba	1timo	re N	4D
permit. Pages Department of I Important: if Ite any injury or of	ł.	21. Signature of Funeral Service L	icensee C	Todd Di	. 2	2. Name ar	nd Address of Fa	acility					
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2		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	t caused the d	eath. Do not en	ter the mod	le of dying, such	as cardiac	or respirato	ory arrest,			Approximate Intervat Between
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Phys or this aral di	. To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o		28c. Injury at Work?	1 ruising in			njury occurr		y)
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	Medical C		Physician: To t examiner: On the and ma										
Vithin To the Comple	Me	29b. Signature and title of certifier	~			29	c. License numb	oer		29d.	Date signer	d (Month,	Day, Year)
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10		30. Name and address of person	who completed	use of death (	(tem 23a) (Type	, Print)		757] istevst		1 1	~	1	20,000
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Regis	trar	MAR 0 1 20	JUI NAME	مار مرايد	A STATE OF								

Joseph Henry Butter 07-00339 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 12, 2007 0507 hrs **Medical Examiner** Henry Joseph Butler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5524 Walker Mill Road Capital Heights Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreign Months Days Hours Director Country) Maryland 54 1**X** M 2 08/16/1952 219-56-1461 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits any Prince 1 X Yes 2 No or 28a-f show items 23a or 28a-f shoust be notified at once. Georges Capital Heights death with the Maryland Maryland 10g Citizen of What Country' 10f Zip Code 10e. Street and Number 這 20743 USA 5524 Walker Mill Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 8lack White, etc. 2 X Married 1 Never Married 2 X No Yes f Yes, Give Year Widowed 1 Yes 2 X No specify: Specify Black Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyggene. autt. If tem 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ð 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Government Laborer D.C 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Butler Sr. James R Marv Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a Informant's Name/Relationship (Type, Print ) Woodlark Dr. District Heights, Maryland Tracey Mullins/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Leartment of Important: If injury or other Burial 2 X Cremation 3 Removal from State crematory or other place) 01/19/07 Alexandria, Virginia Donation 5 Other Specify. Metropolitan 22. Name and Address of Facility Adams Funeral Home PA 21 Sign tire of Funeral Se icensee 20605 Aquasco Rd. Aquasco, Maryland 20608 -Cecil Estep 1348 Part I. Enter the issase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician /Medical Death Smoke inhalation and thermal injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pur 11 per inf g882 8-22-08 vt Physician/Medical X UNPENDED perME, g865, 3/16/07 TT ing phys IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify)

Hospital or Attending Physician: The law requires that the death certificate be Box 68760, Division of Vital Records, P.O. certificate

Completed Be After Certification: after death

1 Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other. Scene DOA ER/Outpatient 3 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c Injury at Work? 28d Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 X No 1/12/2007 subject in fire 4:41 am 2 X Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) 5524 Walker Mill Rd Capital Heights, MD 28e Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) residence 4 Homicide 29a Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

or

To the

30 Name and address of person who completed calle of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner

2007

0 1

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E.

29d Date signed (Month, Day, Year)

January 12, 2007

State Registra

Medical

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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			1 - For State Registrar	State of Maryla	ind / Depa	artment of H	lealth and I	Mental Hyg	iene () () ·	7 06171
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  Aa, Facility Name (If not institution, give s	E. BROD treet and number) V NUPSIM	ERI	ck	Location of Death	2. Date of Death	Day Ye	007 D:15 PM
	Funeral Director		5. Social Security Number 6. Sex 214-01-4979	M 2∏ F 7. Age (In yo	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/12/	Year) 9. 1913 N	Birthplace (State or Foreign Country) ARYLAND
	Maryland a-f show	ctor	10a. State 10b. County  MD HOWARD		WEST FR	cation IENDSHIP				10d. Inside City Limits 1 ☐ Yes 2 ☐ Xio
	with the	al Dire	10e. Street and Number 12465 BARNARD WAY			10f. Zip Code 2179	)4	10	g. Citizen of What USA	: Country?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "naturel", or Items 23s or 28s-1 show event. It a Medical Exertire roust be rodified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spanic Origin? (Spanic Origin) (Spanic Origin) (Specify:	pecify Yes or No- p Rican, etc.)	14. Race - A	merican Indian, /hite, etc. WHTTE
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Maryland	should be nd Mental marked c	ToB	WILLIAM BROSNAN  19a. Informant's Name/Relationship (Type	ne Print)	19h Mailin	g Address (Street a		E ELMORE	City of Town State	a Ta Cadal
	1 and 2 s Health ar tem 27 ls		RONALD C. BRODERIC	K/SON	1246	BARNARD	WAY WE	ST FRIENL	SHIP, MD	21794
Baltimore,	Pages ent of nt: If it		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ Ro  4 □ Donation 5 □ Other (Specify)	moval from State		sition (Name of natory or other place ARK CEMET)	e)		Oc. Location - City  BALTIMORE	
Balti	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service License		22		s of Facility TH	E JOHNSON	I FUNERAL	HOME, P.A. 21286
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	deac	er the mode of dying	-3	or respiratory arre	0	Approximate Interval Between Onset and Death
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	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (	29a. Certifier 1 Strifying Physic (Check only one) 2 Medical Examin	cian: To the best of my kn ar: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place, finion, death occurr	and due to the cau red at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
)	To the within To the Comp	M	29b. Signature and title of certifier	CANDO	MAN	29c. License	G S &	290	d. Date stoned (Mo	nh, Day, Year)
	5		30. Name and address of person who cor	npleted cause of death (Ite	(CCC)	Ellice	of C	For My	ary) oc	021642
1	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 0 1 200	32/ lelgistrar's Sign	ature 6	1				

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46.	Physic /Medi		Raymond L. Cla	arle 3	) (	•	Month	21 700 7	8.20 AM
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		Corning	4c. County of Dea	ith
1			Howard County General Hospi		Columbia			Howard	
r	Funeral		5. Social Security Number 6. Sex 7. Age 13. M 2. F	(In yrs. last birthday) 7/1 Yrs.		If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye /23/193:	ear) 9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	74 Yrs.		7	/23/193	2 M	D "
	yland Jow at		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh iffed	iot	MD Anne Arundel	Hano	ver				1 ☐ Yes 2X No
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	<b>Funeral Director</b>	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Co	ountry?
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ם	2 should be filed and Mental Hygi Is marked other aumatic event, t	Be C	17. Father's Name (First, Middle, Last)		18	8. Mother's Name (Fi	rst, Middle, Maid	den Surname)	
<u> a</u>	Ment Ment arked atic e	To	Raymond Leo Clark Sr.			Iris	Margare	t Jones	
Maryland 21215-0036	2 shot and is and is aum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and				Zip Code)
<u>2</u>	1 and Health em 27 ther tr		Mrs. JoAnn Clark/wife	7410	Locust Dr.	, Hanover	MD 2107	76	
JO.	Pages 1 nent of F ant: If ite ury or ot		20a. Method of Disposition 1   ☐ Burial 2 □ Cremation 3 □ Removal from State		sition (Name of matory or other place)	Date		. Location - City or	Town, State
Baltimore,	it. Pa rtmer rtant: njury		4 □ Denation 5 □ Other (Specify)		en Cemetery		07   G1	en Burnie	e MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign fur of Fureral a rvice Licensee MO1:	364 1	Second Ave	e SW Glen	Burnie	neral Hom MD 21061	ne P.A.
			23a. Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician	H	Immediate Cause (Final disease or condition	eno ke Car	disvascula	n Apco	ne		Onset and Death
	/Medical Examiner		(esulting in death)	consequence of):	disvastate ong Cano				
*		<u>.</u>	Sequentially list conditions, b. Ne for	consequence of):	ong lane	ev :			
Г	ited nsit	nine	cause. Enter Underlying Cause (Disease or injury	onsequence or):	V				
,	execu n and al-tra	Examiner	resulting in death) Last	consequence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical							
9	tificat ig phy as th	ledi							
Box	death certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf		le			23d. Date of deli	verv
Э.	ed for	sicia	in the past 12 months?  1 Yes 2 No  1 Yes 2 No  1 Unknown		Ectopic pregnancy   Other (specify)			Month	Day Year
<u>о</u>	at the de i by the stached	Phy	9 - OIKIOWII						
Ś	w requires that been signed to should be deta	þ	Part II. Other significant conditions contributing to death but r	ot resulting in the un	iderlying cause given in	n Part I.	23e. Did tobacc	o use contribute to	the cause of death?
0	requi	ted					1 ☐ Yes	2 ☐ No 3 ☐ Pro	bably 4 Unknown
Vital Records,	ne law has b	Completed					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
<u>=</u>	sician; The I certificate ha irector, page 3	S					performed? 1□ Yes 2☑1	death?	2 □ No
=	Physician; this certific; ral director, I	Be	25. Was case referred to medical examiner?			. Place of Death (Ch			
ō	Jis D	<u>د</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient  27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA Other:	4 ☐ Nursing Home	5 Residence	6 □Other (Spec	ify)
0	ding F th. : After : funera	tion	1 Natural 5 Pending (Month, Day You 2 Accident investigation	(ear) Injury	Work?	2 No 28d.	Describe how in	jury occurred	
DIVISION	Atter r deal ector	fica	3 Suicide 6 Could not be determined 28e. Place of injury	- At home, farm, stre			ocation (Street	and Number or Ru	ml Pouts Number
2	al or	Certification:	4 Homicide determined building, etc. (s	Specify)		1 6	City or Town, Sta	ate)	ar noute iyumber,
			29a. Certifier (Check only (Ch	ny knowledge, death	occurred at the time, o	date and place, and c	lue to the cause	(s) and manner as	stated.
	the H iin 24 the F iplete	edical	one)	ammation and/or inv	estigation, in my opinio	on, death occurred at	the time, date a	and place, and due	to the cause(s)
	<b>5 1 1 1 1 1 1 1 1 1 1</b>	2	29b. Signature and title of certifier		29c. License nu	mber	29d. D	Date signed (Month	Day, Year)
,			2 Ulanu		1) 30	641	le.	bruary o	27 2007
	10		30. Name and address of person who completed cause of death Rameih Sabapalm 201-109 B	1 (Item 23a) (Type, P GCK Rive	Print) Neck 12c	oad Ba	Ihmor	e Mary	land zuzz
	Stat Registra		29b. Signature and title of certifier  29b. Signature and title of certifier  20c. Name and address of person who completed cause of death  20c. Name and address of person who completed cause of death  20c. Name in Sabagaim 201-109 B  31. Date filed (Month, Day, Year)  32. Registrar's  MAR 0 1 2007	Signature	,	•		/-	

DHMH 17 Rev 1/2001

State Registrar TOOA

M.D.

POOLE RD WESTMINSTER MD 01150

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOGNINA

32 Régistrar's Signature

6-OURISITANK

31. Date filed (Month, Day, Year)

MAR 0 1

			1-	For State Registrar		State o	f Marylar	nd / Depa		t of H	ealth a	and M	-		4007	06174
	Physicia		1. 🖸	ecedent's Name (First,	Middle, La	ist)							2. Date of De. Month	ath Da	y Year	3. Time of Death
	/Medic			FRANCES CI	CATE	LI							Februar		4, 2007	6:40A M
}	Examin	er		Facility Name (If not ins			mber)				Location o	of Death		4c.	. County of Dea	
				15205 Emor		e Sex	7. Age (In yrs.	last hirthday)		ckvi		24 Hrs.	8. Date of Bin	h	Montgo	
	Funeral Director			30-05-5690		1  M 2	90	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	916 New	thplace (State or Foreign ountry) - Vorsk
	Ð		Usu	al Residence of Deced	ent								sept.	1.091	DIOTHEM	TOTK
	show	_	10a	. State 10b. 0	County			ty, Town or Lo								10d. Inside City Limits
	Ba-f	ecto		-	ntgon	nery	Ro	ckvill							·	1 ☐ Yes 2 No
	with ti	ă		Street and Number	-				10f. Zip					10g. Cit	tizen of What C	ountry?
	ns 23	erai		5205 Emory Marital Status	Lane	12 Was Dec	edent Ever in U	S 13		)853	spanic Orio	ain? (Sp	ecify Yes or No		ted Sta	
(0	r iten	Funeral Director		1 Never Married 2[	Married	Armed Fo	orces? 2 🔯 No		If Yes, spec	offy Cuba	n, Mexican	i, Puerto	Rican, etc.)		Black, Whi	
<u>ල</u>	ral', o	þ		3 ¼ Widowed 4 □ Di	orced	If Yes, Gir Year or D	ve		1 ☐ Yes :	2 <u>K</u> J No	Specify:				Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at	Completed			cedent's E	ducation ade completed)		16a. Dece	kind of wo	rk done d	turing most	t of work	ing	16b. K	ind of Business	/Industry
12	within ane. than	m	E	lementary/Secondary (	)-12)	College (	1-4or 5+)		<i>bo not</i> us emaker		)			Or.	vn Home	
D	filed Hygis ther	ပိ	17.	12 Father's Name (First, M	liddle, Lasi	1)		Home	maker	- T	18. Mothe	er's Name	e (First, Middle,			
Maryland	id be ental ked c	To Be		Anthony Gra	ndaza	zo						Not		aila	· ·	
ary	shou and M mar umat			. Informant's Name/Re				19b. Mailir	ng Address	(Street a			al Route Numbe	er, City o	or Town, State,	Zip Code)
Σ	and 2 aulth a n 27 i			Eugene Cica	tell:	i/Son		15205	Emor	у La	ine, l	Rock	ville,	Mary	land 2	20853
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 te marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		20a	. Method of Disposition 1 ☐ Burial 2 1 Crem	ation 3.	Removal from	-	Place of Dispo cemetery, crei	matory or o	ther place	e) F	ebru	ary 28,	20c. Lo	ocation - City or	Town, State
Ē	Pag tment tant:			4 □Donation 5 □ O	her <i>(Speci</i>	fy)	Cre	ntgomer ematori	lum, ]	Inc.	i	200	7	Bet	chesda,	Maryland
Bai	Depar Mpor mpor my in		21.	Signatura of Ft neral S	ervice Lice	200	24004	RC RC	2. Name an OCKVI]	d Addres	s of Facilit	y Roll 30	O West	Pum Mont	pnrey r Egomery	uneral Home/ Avenue
			23:	a. Part1. Enter the dise	se or con	polications that	MOO8	NOS Ro	<u>ockvi</u> ]	Lle,	Mary.	land	20850	<u> -280</u>	)5	Approximate
	Dhysisian		lmi	shock, or heart failure nediate Cause (Final	e. Listonly	one cause on e	each line.				,,	04.040				Interval Between Onset and Death
	Physician /Medical			ease or condition ulting in death)	-	a	cer of		ancrea	18						
	Examiner		Sad	cupationly list opeditions	- 1	b										
T	D #	iner	cau	quentially list conditions by leading to immediat se. Enter Underlying			or as a consec	uence of				-				
V	and and trans	Examiner	tha	use (Disease or injury t initiated events ulting in death) Last		c.	(or as a consec	uanoa of):								
,094	res that the death certificate be executed igned by the ettending physicien and be detached for use as the burial-transit	calE		,	ı		(0) 43 4 00/1340	(uerice or).								
687						_ d.										
Вох	n cert	N/M		EMALE: b. Was decedent pregn.	ant		tcome of pregn		3						23d. Date of de	livery
B	deat	Physician/Med		in the past 12 months 1 ☐ Yes 2 🖁 No	?		nant at time of o		Ectopic pr Other (sp						Month	Day Year
P. 0.	at the	Phy		9 Unknown							1		T			
Ś	The law requires that the death certifica ste has been signed by the ettending ph page 2 should be detached for use as th	by	Fan	II. Other significant c	onditions	contributing to a	eath but not res	suiting in the u	naertying c	ause give	n in Part I.					o the cause of death?
Ö	w require been sign	etec	_						-							
Vital Record	The law cate has	Completed	-										24a. Was autop perfo		24b. Were a prior to death?	utopsy findings available completion of cause of
ta		a)	25.	Was case referred to r	nedical	T					OS Place	of Doott	1 ☐ Yes		1 Yes	2 □ No
$\leq$	ysici is cer direct	To B		examiner? 1 ☐ Yes 2 📉 No		Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	A Othe					6 □Other (Spe	acify)
n of	Attending Physician: r death. sctor: After this certifics by the funeral director, I			Manner of Death 1 ☑Natural 5 □	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	f 2	Bc. Injury Work	at		28d. Describe I			
sio	eath. or: A	catio		2 Accident	nvestigatio				М	1 🗆 🗅	/es 2 □ I	No			·	
Division	or At ofter d Direct in by	Certification:		4 Homicide	determined	4   286. Place	of Injury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tox			ural Route Number,
	spital ours e		298	a. Certifier 1 🕅 C	ertifying P	hysician: To the	hest of my kno	owledge deat	h occurred	at the tim	e date an	d place	and due to the	20150/6	\ and manner a	n stated
	To the Hospital or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	Medical		(Check only 2 M	edical Exa	miner: On the b	asis of examina	ation and/or in	vestigation,	in my op	oinion, dear	th occurr	ed at the time,	date and	d place, and du	e to the cause(s)
	To th withir To th	Ň	29t	. Signature and title of	certifier	1	10	1	290	. License	number			29d. Da	te signed (Mon	th, Dey, Year)
,				1 Lines	reve	Wiso	Wen	SE 1	nd)	00064	4615			Febi	ruary 2	6, 2007
	0			Name and address of							_	,				
	*		_	Genevieve Date filed (Month, Day	my"		M.D. 1 Registrar's Signa		ccard	Dri	ve, R	ockv	ille, M	ary.	Land 20	0850
	Sta Registr		51.	MA		2007	Constraint Sign	A A	mark.	1						
			L			A. C.	THE WAS THE	100	A. A. A.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #9,11, perFh, G865, 3/1/07 TT Certificate of Booth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 930 P ILLIAM 2007 24 /Medical -ebruary 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ELIZABETH NURSING HOME IMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) N.C. 7. Age (In yrs\_last birthday) 5. Social Security Number **Funeral** 1☑M 2□F Months Days Hours 89-16-1728 Yrs. Director NOV. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Directo MARYLAND 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after arent of Health and Mental Hygiene. ant It Item 27 Is marked other than "natural", or Ite any or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married - <del>2 □</del> 1 ☐ Yes 2 🗷 No Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12)
3 RD GRADE College (1-4or 5+) USTODIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MON (DAUGHTER YNTHIA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. FOREST 63-05-07 OWINGS MILLS, M.D. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2/40 N. Fulton Avenue Brown, Jr. Funeral Home Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) wou /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Line to (or as a nonsequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 certificate ha autopsy 1 Yes 25. Was case referred to medical examiner? funeral director, To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 20 No 1 ☐ Yes Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No ours after death.

neral Director: # 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29c\_License number

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR 0 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yele was Lipnik, 720 wasclen

32. Registrar's Signature

Feb., 26, 2007

			1- State Amend #20b Per FH G865 3/01	peartment of Health and I Certificate of Death		ne <sub>No.</sub> 2007	06176	
1	Physici	an	1. Decedent's Name (First, Middle, Last) FREDERICK ARTHUR DORSEY, SR		Date of Death     Month	Day Year	3. Time of Death 12:28P M	
	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4c. County of Death			
	Funeral		3403 DEVONSHIRE DRIVE  5. Social Security Number  6. Sex  7. Age (In yrs. last birth	Months Dave Hours Min	8 Date of Birth	N/A  9. Birthple	ace (State or Foreign	
	Director		218-40-9644	s.	(Month, Day, Ye. 01/31/1	943 MAR	ÝLAND	
Marylan	Marylan f show ied at	ro	10a. State	IMORE CITY		10	od. Inside City Limits 1 X Yes 2 □ No	
	th with the 23a or 28a- ust be notif	ral Director	10e. Street and Number 3403 DEVONSHIRE DRIVE	10f. Zip Code 21215		Citizen of What Count	iry?	
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show diral Examiner must be notified at	by Funeral	11. Marital Status  1 ☑ Was Decedent Ever in U.S. Armed Forces?  1 ☑ Wever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	<ul><li>13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes</li></ul>	pecify Yes or No- Di Rican, etc.)	14. Race - America Black, White, e	etc.	
21215-0036	within ene. than "	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) RRECTIONS OFFICE	king S	TATE OF	ustry	
Maryland 2	uld be filed Mental Hygi rked other ric event, ti	To Be Co	17. Father's Name (First, Middle, Last) CHARLES EDWARD DORSEY		ne (First, Middle, Maid	den Surname)		
Mary	and 2 should salth and Mer n 27 is marke er traumatic			failing Address (Street and Number or Ru $403\; ext{DEVONSHIRE}\; ext{D}$			*	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr			Remain Action 1 3 / 6	Date 20c.	Location - City or Tov	vn, State	
Balti	permit. Departn Imports any Inji		21. Signature of Septeral Service Licensee	22. Name and Address of Facility HO	IGHTS AV	ERAL HOME	E 21207 MORE, MD	
a a	Physician /Medical		23a. Pan Em. r the disease, or complications that caused the death. Do no shock, or heart future. List only one cause on each line.  Immediate Juse (Final disease condition a. Cart Cart Cart Cart Cart Cart Cart Cart	lyo cardial In	or respiratory arrest,	r (	Approximate Interval Between Onset and Death	
	Examiner		Due to (or as a consequence of	sion	Y	years		
68760,	icate be executed physician and the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (o/styla consequence of consequence)  C. Due to (o/styla consequence of consequence)	sterolemia		u u	years-	
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	y Day Year	
	quires that en signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in ti	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?	
Division or Vital Records,	The law re ate has bee	Completed			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of	
Vita	/slcian: s certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	C4h	th Check onl one	e 6 □Other (Specify)		
ion or	nding Phy ath. r: After this ie funeral c	ation: To	27. Manner of Death  1 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Tir Injury	ne of 28c. Injury at	28d. Describe how in			
Divis	tal or Atters as after deal Directored in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,	
	ne Hospi n 24 hou te Funer pletely fill	Medical	29a. Certifier (Check only one)  1	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)	
<b>n</b>	Mithii To th	M	29b. Signature and title of certifier	29c. License number 0000 383		Date signed (Month, D $2 - 2 P - 0$		
	3				ant To	ulson, 11,	,	
	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type CARLOS E. ARANAGA M.D. C. 31. Date filed (Month, Day, Year)  MAR 0 1 2007  MAR 0 1 2007	INI 'IL CHARLES OF	ect Sa	ule 4202		
	Regist	ar	MAR U I ZUUT KILAWA JA A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #5, perInf, \$500, 4/5/0/ II Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Florence Ruth Denny February 25, 2007 7:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6230 Valley Road Bethesda Montgomery 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 074-14-4849 074-16-4849 Usual Residence of Decedent 1□M 2ÅF 85 Director New York 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "netural", or iteme 23a or 28a-f ehow ury or other traumatic evant, the Medical Examinar must be notified at 10b. County 1 Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6230 Valley Road 20817 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygienist Denta1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Frank Baker Ruth Frances Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleve B. Denny / Husband 6230 Valley Road, Bethesda, Maryland 20817 March 2, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Gate of Heaven Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licen M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Ovarium Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed certificete has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 🔯 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗵 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ieral Diractor: After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of eximination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 5 5 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0033293 February 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D. 5454 Wisconsin Avenue, #1300, Chevy Chase, MD 20815-6908 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State Registrar 2007

		1	For State State Registrar	ate of Maryland		artment of H		and Mer		ene () ()	7	061	78
			Hegistrar     Decedent's Name (First, Middle, Last)					2.	Date of Death			3. Time of I	Death
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	/Medic		KATHERINE RC  4a. Facility Name (If not institution, give street		.V.S	4b. City, Town, or	Location of		<u> </u>	4c. County		1	-F
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_			5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under		Date of Birth		9. Birthp	lace (State or	Foreign
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ING ZIZIS-UUSO be filed within 72 hours after death with the Maryland	n the	lre	10e. Street and Number	10f. Zip Code			10		zen of What Country?				
	h wit	Funeral Director	600 Light Street Apt. 304 21230							.A.			
	deal	ner	11. Marital Status 12. W	/as Decedent Ever in U.S. med Forces?	. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Ori	gin? (Specify	y Yes or No- an, etc.)		e - Americ k, White,	etc.	
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$\frac{3}{5}$	narke narke	٩	Harry Musgrove  19a, Informant's Name/Relationship (Type, F	trint)	19h Mailir	ng Address (Street a						Code)	
<u>a</u>	12 st h and 7 is n treun			Daughter)	600 L	ight Stre	et Ap	ot. 30	4,Balti	more,	Mary.	land 21	1230
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department if item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, it is Madical Examinating the notified at once.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of matory or other plac		Date	9 2	Oc. Location -	City or To	own, State	
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Ь	/Medical Examiner		resulting at death)	Due to (or as a conseque								wa.	
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	be is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury	LRP	51100 01).							fn	
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Δ.	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Ph	Part II. Other significant conditions contribu	iting to death but not resul	ting in the u	inderlying cause giv	en in Part i	1.	23e. Did tob	acco use con	tribute to t	he cause of d	eath?
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o	Phys this ral di	10	1 Yes 2 No 27. Manner of De th 2	1 ☐ Inpatient 2 ☐ E 8a. Date of Injury	28b. Time o				d. Describe ho			y)	
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Division	or Attendate death Director:	ertif	4 Homicide determined	building, etc. (Specify,	)				City or Town	, State)			
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	24 ht Fun stely	edical	(Check only 2 Medical Examiner:	On the basis of examinati and manner stated.	on and/or in	nvestigation, in my o	pinion, de	ath occurred	at the time, da	ite and place,	and due t	o the cause(s	)
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7	1		30. Name and address of person who compl	eted cause of death (Item	23a) (Tun-		• 01	9			U		
	h		Scalin 2501	Las or dealing them		Southo		(NV)	2	1224	\		
		ate	31. Date filed (Month, Day, Year)	32. Signat	ure (	0		. • ,		-	•		
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07-01361 David Frasier, Jr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician cal Examine	~	David	Frasier	Jr.			Date of Death Month Da February 18,	y Year	3. Time of Death 1400 hrs
cai Examine		a. Facility Name (if not institution, give str Johns Hopkins Hospital		4b. C	ity, Town, or Loc		rebruary 18,	4c. County of Death	
Funeral Director	- 1	6. Sex 212-90-6271	7. Age (In yrs. last 29	birthday) If	Under 1 Year   I	f Under 24Hrs. Hours Min.	8. Date of Birth (M	M/DD/YYYY) 9. Bir	
w any		Jsual Residence of Decedent  Oa. State  10b. County		own or Location					10d. Inside City Limit
ith the Maryland  23a or 28a-f show notified at once.	Director	MD N/A  10e. Street and Number	Ва	ltimor <sub>10</sub>	Zip Code		10g. (	Citizen of What Cou	1 XYes 2 No
orth the No. 23a or 25 notified		1508 E. Chase	Street . Was Decedent Ever in U.S.	13. Was De	2121		ifv Yes or No-	USA 114. Race - Amer	ican Indian, Black,
or death w	Funeral	1 XNever Married 2 Married 1 1 3 Widowed 4 Divorced If Y	Armed Forces? Yes 2 X No	If Yes, s	pecify Cuban, Me	exican, Puerto Ri		White, etc.	ack
hour 'natu	ted by	15. Decedent's Education (Specify only h	Dates:	6a. Decedent's U		(Give kind of wor		b. Kind of Business/	
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nd 2 shoull alth and M m 27 is m aumatic		19a. Informant's Name/Relationship (Type, Geraldine Lisbo	n-mother	1737	Ensor S	Street	Baltimo	ore, MD	21202
permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic	Ì	20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State crer	ce of Disposition matory or other p	el Cem.	2/2	7/2007	c. Location - City or Baltimo	ore MD
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tg eg e	Physician/M	3b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar Live birth Pregnant at time of death Unknown	2 Fetal d	eath 3 [] (Specify)	Ectopic pregnanc		23d. Date of deliver Month I	y Day Year
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law requires has been sign 2 should be	Completed						24a. Was an autopsy performed	24b. Were at prior to death?	utopsy findings availab completion of cause of
ysician: The lav his certificate ha director, page 2		25. Was case referred to medical			26. Place of	Death (Check on	1 Yes 2 ly one)	No 1 ✓ Y	es 2 No
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Lator Attending Physician: The law requires that it is after death.  To after death.  To after death.  To after death.  To after this certificate has been signed by led in by the funeral director, page 2 should be detact.		27. Manner of Death  1 Natural 5 Pending  2 Assistant Investigation	FOUND: FOUND	8b. Time of Injury FOUND: 1306 hrs			8d. Describe how ubject shot	injury occurred	
ital or Attencurs after death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 W Homicide 1 Homicide 1 Could not be determined 1 Could not							
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or	To the best of my knowledge, the basis of examination and	, death occurred d/or investigation,	at the time, date in my opinion, de	and place, and dieath occurred at t	ue to the cause(s)	and manner as star	ted. ne cause(s)
To with To com	Med	29b. Signature and title of certifier	d manner stated.		29c. License ni O.C.M.I	umber	29	ebruary 19, 20	onth, Day, Year)
7	ŀ	30. Name and address of person who com Carol Allan, MD Assistant	pleted cause of death (Item 23 Medical Examiner 1	3a) 11 Penn Stre	et, Baltimore	e, MD 21201			
Sta	ate	31. Date filed (Month Ray, Year) 2007	32. Segistrar's Signature		23				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 06180 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Blanie Gorham, Jr 1:42 Feb 17, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 3204 Harwell Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days 1 N 2 F Hours Min Director 218-02-3094 Jan 4, 1972 Md Usual Residence of Decedent death with the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Md **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204 Harwell Avenue 21213 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene.

other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ **N**o Baltimore, Maryland 21215-0036 Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Production 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Blanie Gorham Sr. Ruby Lee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 3204 Harwell Avenue Baltimore, Md 21213 Nickille Gorham Wife Department of Heal Important: If Item 2 any injury or other or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Borial 2 ☐ Cremation 3 Removal from State 02/23/07 4 □ Donation 5 □ Other (Specify) Baltimore, Md Gardens of Faith 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meladiduc **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a, Was an has page certificate 1☐ Yes **₹** No Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence funeral dir 6 ☐Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EATER AVE BATIMORE 40 MILHAIZL 31. Date filed (Month, Day, Year) MAR 0 1 2007 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 **Physician** Jane Parker Graham February 2007 12:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 22 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) PA 1□M 2∏F 196-34-8788 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be routified at once. 10a. State 10b. County 10d. Inside City Limits Md Carrol1 Sykesville 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7200 Third Avenue USA 21784 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bess Kroh Joseph L. Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Clevenger (trustee) 45 W. Main St., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 XRemoval from State 4 Donation 5 Dother (Specify) 3-5-07 New Bethlehem Cem. New Bethlehem, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Harget Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finat disease or condition resulting in death) infaction Myocardial **Physician** minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the e ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown leted 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Compl certificate anoveria 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death [Check only one] examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 Vo 2 this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury af Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) Vithin 2 29b. Signature and title propertifier 29d. Date signed (Month, Day, Year) D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Eldersburg Tan MD 1645 Liberty William 32. Resistrar's Signature State Registrar

State Registrar HAVON

31. Date filed (Month, Day,

6701

N. Charles &T BARMOR MD ZIROZA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb **Physician** 6:34 enneth. Green 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** University of Maryland Medica Ctv. Baltmore Baltmore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 219-32-0949 Director 69 25 1938 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Wes 2 ☐ No Director MD N/A Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 5306 Denmore Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumait. 12th Home Improvement N/A various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be V . Green Virginia ဥ I. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Brooks Lane Baltimore, MD Sheila Green-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Mt. 3/1/2007 Carmel Cem. Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST N ans 1101 E. North Avenue Baltimore, MD 21202 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pneumoniz Physician pranor disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any bearing to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit April 1 Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Year Day 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ Bladder cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Pericardial tamponade 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ Vo 24a. Was an was ... autopsy performed? Yes 217 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Watural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU 4176435515688 Feb 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balmor MD 21201 Greene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAR

Year)

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2007 February 1832 Margaret H. Graziosi 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 29, 1921 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F 285-16-3172 85 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9615 Marathon Circle #104 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Houhoulas Angela Pascolas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry Graziosi / Daughter 9615 Marathon Ter. #104, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 27, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2007 New Cleveland Cemetery Cleveland, Mississippi 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rotert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01473 23a. Parti. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTILOBAR PNEUMONIA disease or condition resulting in death) DAYS Due to (or as a consequence of): HEART CONGESTIVE FAILURE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): OBSTRUCTIVE PULMONARY CHRONIC YEARS Due to (or as a consequence of): FRACTURE Non IRAUMI ONE DAY HIP IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Othe 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTEOARTHRITIS DEMENTIA 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC 24a. Was an autopsy performed: 2 X No DIABETES 1YPE 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation STOOD UP AND SIMPLY FELL FEBRUARY 20 2007 0600 AM 1 ☐ Yes 2 X No 2 Accident

Examiner certificate be executed burial-transi and Box 68760. attending physician for use as the buria ned by the at e detached fr P.0. Records, has or Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Items 23a

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Item 27 I

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**Physician** 

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72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Examiner

Physician/Medical

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Certification:

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(Check only one)

29b. Signature and title of certifier

29a. Certifier

certificate this funeral After death. after death filled in by the

within 24 hours a

To the Funeral I

completely filled

Division

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIJIT DASGUPTA MD

MAR 0 1

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

9615 MARATHON TERR, APT 104

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0064444

29d. Date signed (Month, Day, Year) FEBRUARY 22 2007

9901 MEDICAL CENTER DRIVE

ROCKVILLE MARYLAND

HOME

31. Date filed (Month, Day, Year)

2007



			For State Registrar	State of	Marylan	d / Depa	artment rtificate	of H	ealth a	and M	ental Hy	giene (	007	06185
	Obveisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Nan Dressler Grav	res							Februar			9:45 P M
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			Brighton Gardens				M. I. I. and a second		kvil]					gomery
	Funeral		5. Social Security Number 6. Security Number 1	9x 7. □M 2⊠F	Age (In yrs. 90	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day	h v, <i>Year)</i> 1016		place (State or Foreign
	Director		Usual Residence of Decedent								June 1,	1916	New	Jersey
	land ow		10a, State 10b, County		10c. Cit	y, Town or Lo	cation							IOd. Inside City Limits
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<b>d</b> 2	E F E		17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Sur	mame)	
Maryland 21215-0036	Q 20 0	To Be	Morris Joseph Dre	essler					M	inerv	a Carol	line L	ehmann	ı
2	s 1 and 2 should t f Health and Ment item 27 ie marked other traumatic e	-	19a, fnformant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	and Numbi	er or Rura	Route Numbe	r, City or To	wn, State, Zip	Code)
Ž	ath a		Ralph Rollo-Son-	in-Law		2250	5 Rob	in C	ourt	, Gai	thersbu	irg, M	lary1an	d 20882
Ē,	other		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	ne of	(a) T	Febru	ate	20c. Locati	ion - City or To	own, State
E	Pages ment of h ant: if its ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te Vet	rownsv erans	ille Cemet	ery	2	27 <b>,</b> 2		Crow	msvill	e, Maryland
Baltimore,	permit. Page Depertment Important: if eny injury or once.		21. Signature of Funeral Service Eigen	500	MO1	22	2. Name and	d Addres	s of Facili	ty Roh	ert A. e Inc. 20814	Pumph 7557	rey Fu Wiscon	neral Home/ sin Avenue
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⋚	Physician: this certific al director,	0 8	examiner?	Hospital: 1 Inp	ationt 2	ER/Outpatier	nt 3 DO	Othe	nr.		Check only one 5 ☐ Resid		Other (Cons	L.I
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	M)		30. Name and address of person who	•			•	6.1	D 1		34-	1 0	0050 0	046
	IV		Rita Ghosh M.D.  31. Date filed (Morth, Day, Year)		ysicia İstrar's Signa		e, #1	01,	KOCKY	ville	, Mary	Land 2	.0000-3	740
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1- For Amend #20b, perFH, g865, 3/1/07 TT Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** February Deloves 2007 1830 52 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MORE NIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 25 9 -28-025 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rthan "naturel", or items 23e or 28e-f show the Medical Examinar rough be multiled at 1 ØYes 2 No Director MARYLANN 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygient Important: If item 27 is marked other the eny injury or other treumatic event, Inc. 2006. HIGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HRISTINE 20b. Place of Disposition (Name of 20a. Method of Disposition Arbutus 1 Burial 2 □ Cremation 3 □ Removal from State EMETERY 63 -02-TIMORE \* 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest/shock, or heart failure. List only one cause on each line. disease or condition resulting in death) Pnysician arthsons rars /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 3 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 14 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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25 Mari

32. Restrar's Signature

29c. License number

037573

29d. Date signed (Month, Day, Year)

26, 2007

Februar

patient Known as Dorisene Herrell
Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		Please		Black Indelible Ink. Ensure A			
		For	State of Marylan	d / Department of Health and N	lental Hyg	jiene	06187
		State Registrar	4	Certificate of Death	2. Date of Dea	teg. No. C. U U /	3. Time of Death
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/Medic		4a. Facility Name (If not institution, g		4b. City, Town, or Location of Death	Tenuc	4c. County of Death	
Examin	er	Sinai Hospital		ore Baltimore C	ity	N	1A
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. I	last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	9. Birth	place (State or Foreign
Director		Usual Residence of Decedent	5.	5 Yrs.	NOV I	1,1951 Sou	TH CAROLINA
land ow	ľ	10a. State 10b. County	10c. City	y, Town or Location	0/		10d. Inside City Limits
a-f sh ified	ctor	MARJILAND 1	VIA	BALTIMO		ITY	1 X Yes 2 □ No
or 28	Dire	10e. Street and Number		10f. Zip Code	ا	10g. ditizen of What Cou	intry?
ath w	ral	1020 SUR	12 Was Decedent Ever in U.	S 13 Was Decedent of Hispanic Origin? (Sr	ecity Yes or No-	14. Race - Ameri	ican Indian,
after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		, etc.
	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ⚠ No Specify:		Specify: 32	ACK
72 hours natural", dical Exa	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/li	ndustry
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filed v Hygie other i	င္ပ	17. Father's Name (First, Middle, La	st)	18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
should be filed within nd Mental Hygiene. marked other than Imatic event, the Me	To B	J. C.	PEAV	Q. T.	BLA	RKHON	
2 should I and Men is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street and Number or Ru	ral Route Numbe	er, City or Town, State, Z	ip Code)
rt 27		BRIAN HARRE	LL (HUSBAND	NOQO SURRY DK	19AL7	20c. Location City or 1	O LILIO
Pages 1 allount of Hes int: If item iry or othe		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	Removal from State	cemetery, crematory or other place)	15 27	BALE AL	nr 411
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice		22. Name and Address of Facility	200-01	X)AL/1/90.	RE 19D
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/Medical	1	resulting in death)	Due to (or as a consec	quence of):			1
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clan: ertifica	Be C	25. Was case referred to medical examiner?	Unonital: #	Othor	ath Check onl c		
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al or safter	Certification:	4 Homicide determine	building, etc. (Spec		Only or 7 or		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	edical	(Check only 2 Medical E	xaminer: On the basis of examin	lowledge, death occurred at the time, date and plac lation and/or investigation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
thin 24	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Mont	h, Day, Year)
P ≥ 2 8	-	Rhanda Fish	ul mD-Prvedor	V Surpried D28855		H28/07	
7		30. Name and address of person v	the completed cause of death (Ite	m 23a) (Type Print)		•	
r		Rhonda Fish	el MD - Si	nai Hospital			
St Regist	ate trar	31. Date filed (Month, Day, Year)  MAR 0 1	2007 Segistrar's Sign	nair Hospital			

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	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City	, Town, or Location of Death		4c. County of Death	100000
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	Director	5	Usual Residence of Decedent		Town or Location		UT-AT-1	117	Od. Inside City Limits
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Maryland	2 should by and Menta is marked sumatic en	2	Luther U. FK 19a. Informant's Name/Relationship (Tyx	enderson De. Print)	19b. Mailing A	ss (Street and Number of Ru		y or Town, State, Zip	Code)
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altimore,	00		1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	emoval from State	metery, crematory or	rk 3/2	107 E	Baltomo	re, MD
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	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	ence of):				
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Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	a a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnant	death 3 □Ectopic			23d. Date of delive	ery Day Year
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ital F		Be Col	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	No 1 ☐ Yes	2 No
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only one) Certifying Phys	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, death occurre on and/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause irred at the time, date a	e(s) and manner as si and place, and due to	tated. o the cause(s)
	vithin To th Compl	Me	29b. Signature and title of pertifier	10000	2	9c. License number	29d. I	Date signed (Month,	Day, Year)
•	12		30 Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	1100 550	11/10	6.46	00 +
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Segistrar's Signatu	NOT	thwest	Hos	2.	
	Regist		MAR 0 1 20	07 Brown 1	K Brack	D.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Herbert Hyde, Jr. 2:580 M 7 26 07 /Medical 4a. Facility Name (If not institution, give street and pumber) 4b. Dity, Town, or Location of Death 4c. County of Death Examiner HOSLital agnes Ball imore n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 30, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F Months Min. Hours 578-12-0133 Director 94 1913 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23s or 28s-f show other traumstic event, the Madical Examinar must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane 21228 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1942— If Yes, Give Year or Dates; 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> Specify: 3 X Widowed 4 ☐ Divorced White 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Pages 1 and 2 should be filed within tent of Health and Mentel Hygiene. int: tf item 27 is marked other then Elementary/Secondary (0-12) Lawyer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H. Hyde Caroline Virginia Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Harris/Daughter 26700 Purdum Rd Damascus, MD 20872 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or Metro Crematory, Inc 2/27/07 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring

22. Name and Address of Facility

Cremation Society of Maryland,
299 Frederick Rd Baltimore, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (First) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 Other (specify) ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 1 Yes 2 110 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sempletely filled In by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/26/07 D44377 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton 900

DHMH 17 Rev 1/2001

State Registrar Dencen Bowlin,

31. Date filed (Month, Day, Year) MAR 0 1 2007 tal

St. agne

32. Registrar's Signature

07-01425 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 20, 2007 **Medical Examiner** Herman ris 1941 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital 9. Birthplace (State or 5. Social Security Numbe 7. Age (In yrs last birthday) If Under 1 Year f Under 24Hrs. Date of Birth (MM/DD/YYYY) Funeral Davs Hours Director 1 4M Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 V Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show ma, 1A Director 10e. Street and Number 10g. Citizen of What Country nam Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black event, the Medical Examiner must be "natural", or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 Yes 1 Yes 2 No specify: 4 Divorced 3 Widowed If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours arent of Health and Mental Hygiene 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) marked other 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Son WIL 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, \$tate, Zip Code) If item 27 is maither traumatic e Dr. mill Hollinston DWING 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Cremation Burial Removal from State netro mportant: remalde Other Specify 22. Name and Address of Facility 270 Fred HILTON Balton Vary er the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and List only one cause on each line /Medica Death Atherosclerotic cardiovascular disease Immedial Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED attending physician for use as the burial -4#232,27,perME, g865, 3/2/07 TT Box 68760, 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No ✓ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 DOA After this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification 1X Natural Yes 2 the f Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe O.C.M.E. February 21, 2007 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

			For State	State of Maryla		ent of Health and I ate of Death	Mental Hygie Reg.	2001	06191
	Physicia	_	Registrar  1. Decedent's Name (First, Middle, Last,	11	skins		2. Date of Death  Month	Day Year	3. Time of Death
	/Medic	al	KOS I d			ty, Town, or Location of Deatl		24, 2007 4c. County of Death	600a M
1	Examin	er	Maryland Gren	. /	tal Bu	altimore	Coty	NIF	7
	Funeral Director		5. Social Security Number 6. Se	X 7. Age (in yr.		der 1 Year If Under 24 Hrs. Is Days Hours Min.	8. Date of Birth Month, Day, Yo	ar) < _ Cou	place (State or Foreign ntry)
	ס	4	Usual Residence of Decedent	1100	Site Town or Location		1100121		10d. Inside City Limits
	Marylar f e how	ō	10a. State 10b. County	A	City, Town or Location	timese	)		1 Pres 2 No
	or 28e-	lrect	10e. Street and Number	- C-1	-ve 101.	Zip Code	10g	. Citizen of What Cou	ntry?
	e 23e	Funeral Director	3214 Seq.	UDIA H		cedent of Hispanic Origin? (S	opecify Yes or No-	14. Race - Ameri	can Indian.
7S 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If Item 27 le marked other than "netural", or Iteme 23a or 26e-f ehow eny injury or other treumatic event, the Medical Examit at must be notified at once.	<u>۾</u>	1 Never Married 2 Married 3 SW Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White,	
55 5	"netur	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's U	sual Occupation work done during most of wor use retired)	rking 16	Baltin	ndustry
75.25	d withir giene. ir than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	/ / /	eria ivo	rker	City Pu	blic School
and bring	be file Ital Hyg od othe	Be	17. Father's Name (First, Middle, Last)	Griffin		18. Mother's Nar	πe (First, Middle, Ma.	iden Sumame) Parra	
re the	should nd Mer marke	မှ	19a. Informant's Name/Relationship (T)	ype, Print) (	19b. Mailing Addre	ess (Street and Number or Ro	ural Route Number, C		· · · · · · · · · · · · · · · · · · ·
	and 2 eelth a m 27 le		Gloria Cra	_/	er 3214	seguoia Ar	e Baeto	, md, 2	1215
Raltimore,	ages 1 nt of H t: If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Disposition (*) cemetery crematory of	or other place)	Date 20	Location - City or T	own, state
altin	permit. P Depertme Importen eny injury		21. Signature of Funeral Jervice Licent		V - (0-	and Address of Facility	270 Fred	HILTON	Fass
<u> </u>	88 5 8		Just I la	yl_	Gare			toind	21229 Approximate
	Dhamisian		23a. Part1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.		RiOSCIEROTiC		_	Interval Between
	/Medical		disease or condition resulting in death)	a. Sup to (or as a cons		RIOSGACIIC	- cararovas	wich Dixas	<u>k</u>
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):				
$\sqrt{}$	executed n and laf-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c					
,09		al Ex	resulting in death) Last	Due to (or as a cons	equence of):				
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D. Box	es thet the deatr certificationed by the attending pt	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 Ectopic	c pregnancy (specify)		23d. Date of deliv Month	rery Day Year
, P.O.	requires thet the been signed by th hould be detache	by Ph	Part II. Other significant conditions co	ontributing to death but not r	esulting in the underlyin	g cause given in Part I.	23a. Did tobac	co use contribute to	the cause of death?
ords	require een sig nould b						1 🗌 Yes	2 No 3 Pro	bably 4 Dunknown
Rec	he taw has b	Completed			·		24a. Was an autopsy performe	d? prior to co	opsy findings available ompletion of cause of
ital	len: Ti rtificete ctor. pa	Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ath (Check only one)	No 1 □ Yes	2 ∐ No
of ^	Physic this ce at direc	ဥ	examiner? 1 Yes 2 No  27. Manner of Death		☐ ER/Outpatient 3☐ 28b. Time of		dome 5 ☐ Residence		fy)
ion	nding lath.	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
Division of Vital Records,	fter des lirector	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, street, fac ocify)	tory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Attending Physicien: The law require within 24 hours effer death. To the Funeral Director: Affer this certificate has been si completely filled in by the funeral director. page 2 should it		(Check only 2 Medical Exam	iner: On the basis of exami		red at the time, date and place ion, in my opinion, death occ			
_	o the vithin 2 o the	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29d	. Date signed (Month,	Day, Year)
	- >- 0		) A 2	Cure MI		89569		2/24/0	7
	5		30. Name and address of person who c	completed cause of death (I	tem 23a) (Type, Print)	Dar Wand A	reneral,	Nosei ta	<u></u>
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	in grance of	, 4,000	V//	
	Regist	rar	MAR 0 1 20	107 Marian	5 Boske	1			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FEBRUARY 28, 2007 2:30 A.M HAZARD CHARLOTTE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 31,1915 Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M **X** X F Maryland 92 214-01-2191 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X XIII Director Harford Forest Hill MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21050 U.S.A. 1729 Chrisara Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes XXNo Specify. White XXWidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6 alth and Mental Hyc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Emma** Unknown ပ George Ensor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Terri Galiazzo 1729 Chrisara Ct. Forest Hill, MD 21050 Daughter 20b. Place of Disposition (Name of cametary, crematory or other place) Baltimore, 20c. Location - City or Town, State 20a Method of Disposition XXBurial 2 □Cremetion 3 □Removal from State 4 □Donation 5 □ Other (Specify) Meadowridge Memorial Park 3/2/07 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dward Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No. 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient ၉ 28c. Injury at Work? filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1º Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar
DHMH 17 Rev 1/2001

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W.

MAR 0 1 200

31. Date filed (Month, Day, Year)

MACPHAIL ROAD

32. Redistrar's Signature

death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or incorporate.

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be

**Funeral** 

Director

**Physician** /Medical Examiner

law requires that the death certificate be executed and the burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria use as page 2 certificate funeral director,

MO0198 7557 Wisconsin Ave., Bethesda, MD 20814-35

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia disease or condition resulting in death) 1 week Due to (or as a consequence of): Cerebrovascular Accident 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dysphagia 1 Yes 2 No 3 Probably 4 Unknown Completed Trachiostomy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2X No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ours after death.

neral Director: Af
filled in by the fur

DHMH 17 Rev 1/2001

State

Registrar

man

MAR 0 1

Raman R. Tuli, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Apgistrar's Signature

10810 Darnestown Road #202, Gaithersburg, Maryland 20878-2601

February 26, 2007

			For State Registrar	State of Ma	aryland /		rtment of H		ınd Me		jiene	07	06194		
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last Thelma	Heili	nan					Date of Dea Month	th Day	Year 2007	3. Time of Death		
	Examin	er	4a. Facility Name (If not institution, give  TOHNS IHOPICINE I  5. Social Security Number  6. Se	BAYVICE			4b. City, Town, or BITCT		ee_	Date of Righ	4c. County	Im			
	Funeral Director			х Эм <b>2</b> /х Г	e (In yrs. last b	Yrs.	Months Days	Hours	Min	B. Date of Birth (Month, Day HPRIL I	(p 1908	MA	place (State or Foreign ntry) PLY UTND		
	Maryland -f show	tor	10a. State 10b. County MD N/A		10c. City, To		imore					1	10d. Inside City Limits 1½☐ Yes 2 ☐ No		
	th the or 28a e notii	Director	10e. Street and Number		l		10f. Zip Code	7		1	l0g. Citizen of \	What Coul	ntry?		
	ath wi	ral	403 Cornwall Stree			1	2122				USA				
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 271s marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Medical Examinat must be routified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ↑ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2√2 No	Specify:	gin? (Speci , Puerto Ri	fly Yes of No- ican, etc.)	Blac	ck, White,			
21215-0036	hin 72 horan. Bu "natur	Completed	15. Decedent's Edd (Specify only highest grad	cation le completed) College (1-4or 5		(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most	of working		16b. Kind of B	usiness/In	dustry		
21	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Ite Me		8			Punc	h Press (			Tion & Adiabatic	Food		stry		
Maryland	d be fill hall Hall hall hall hall hall hall ha	Be c	17. Father's Name (First, Middle, Last)							rırsı, mıddle, Sticke]	Maiden Suman	ne)			
Ĭ	should be ind Mental s marked o umatic eve	2	Harry Ruskell  19a. Informant's Name/Relationship (T)	ype, Print)	19	b. Mailin	g Address (Street					State, Zip	Code)		
	1 and 2 : Health ar iem 27 Is other treu		Joan Jackson- Daug	hter	4	03 C	ornwall S	Street	Balı	timore,	MD 21	224			
Baltimore,	of He of He of Item		20a. Method of Disposition  Y□ Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place cemet	of Dispo ery, cren	sition (Name of natory or other place	(8)	Da	te	20c. Location -	City or To	own, State		
ţ	t. Pag tment tent: I		*4 ☐ Donation 5 ☐ Other (Specify,		Holly		1 Cemeter		2/28/0		Baltimo				
Bal	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens			6	Name and Address	ern Av	enue	Baltin	nore, M				
	Pnysician /Medical		23a. Part 1. After the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (V as a consequence of):												
	s be executed sician and purial-transit so burial-transit so buria	Examiner													
68760	icate be physicia s the buri	dlcal		d											
O. Box (	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 the No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	′				te of delive	ery Day Year		
rds, P.	sign d be	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.			bacco use cont		he cause of death?		
Record	The law ate has b page 2 s	Completed					-			24a. Was a autops perfor	med?		opsy findings available mpletion of cause of		
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth			Check only or					
ō	ing After unei	atlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 X Inpatie 28a. Date of Inju (Month, Da	ry 28b	Outpatien Time of Injury	28c. Injur Wor	vat k? Yes 2 □ N	28		ence 6 Oth ow injury occur		(fy)		
Division	ef or Attendi s after death. al Director: A ad in by the fu	Certification;	3 Suicide 6 Could not be determined	farm, str	eet, factory, office		28	f. Location (S City or Tow		er or Rura	al Route Number,				
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	29a. Certifier (Check only one)  15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.													
	To the P within 2 To the I complet	29b. Signature and title of certifier 29d. Date signed (Month,								-					
•	1		Groce a Co	rdts M	0		035	763	3	j	Februar	y 2	7, 2006		
	4		Grace A. Cordt	ompleted cause of c	Hopk	(Type,	Bay vie	w Ci	ircle	· Ba	etimor	2,	7, 2006 Nd 21224		
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 1 20	107 Jacon	ar's Signature	Sh	well ?						ŕ		

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i> .		-	iene <sub>g. No.</sub> 2007	06195
	Physici /Medic		Decedent's Name (First, Middle Annie	R .	Jacob	s		2. Date of Deat Month 1	5 <sup>Day</sup> 200 <sup>Year</sup>	3. Time of Death 9:32 A M
	Examin		4a. Facility Name (If not institution 3815 Cranston			4b. City, Town, o Balt	r Location of Death imore		4c. County of Death	NA
444	Funeral Director		5. Social Security Number 240-48-9494	6. Sex 1 ☐ M 2 🔀 F	e (In yrs. last birthday, 88 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-16-	Year) Cou	pplace (State or Foreign intry) N.C.
	ryland how at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	the Ma 28a-f s	ectol	MD N	/A	Baltim	Ore		14	0g. Citizen of What Co	XXYes 2□No
	23a or ust be n	Funeral Director	3815 CRANSTO	N AVENUE		2122			USA	mtuy:
9000	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cubi  1 ☐ Yes 2 ☐ No  dedent's Usual Occup	Specify:			, etc. lack
21215-0036	d within 72 giene. rr than "nat the Medica	Completed	15. Deceden: (Specify only higher Elementary/Secondary (0-12) 5th grade	st grade completed)  College (1-4or 5	(Give	e kind of work done DO NOT use retired	during most of work	ing Unk	16b. Kind of Business/I	ndustry Unk
pu	ld be filed viental Hygis ked other	Be	17. Father's Name (First, Middle,				18. Mother's Nam			
Maryland	should be and Mental Is marked o	은	Hugh Willi  19a. Informant's Name/Relations		19b. Mail	ng Address (Street	Sadie and Number or Rui	Tuci	City or Town, State, Z	ip Code)
re,	ss 1 and 2 of Health a Item 27 Is		Phyllis Jaco 20a. Method of Disposition 1☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State	20b. Place of Disp cemetery, cre Crownsv	5 Cranst osition (Name of matory or other place	ce)	Date 2	20c. Location - City or 1	
Baltimore,	permit. Page Department ( Important: If any Injury or once,	Crownsvil . East imore, Md.								
	2		23a. Part1. Enter the disease, or	complications that caused	the death. Do not en					21202 Approximate Interval Between
	Physician /Medical Examiner	9 9	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a Lun	a onsequence of):	ce,			3	Interval Between Onset and Death
	97 - 7 11	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of);	*.				
68760,	ificate be executed g physician and ss the burial-transit	ledical Examiner	Cause (Lisease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):					
O. Box	the death certif by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. if yes, outcome 1 ∐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	<i>'</i>		23d. Date of deliv	very Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to death bu	ut not resulting in the u	ınderlying cause giv	en in Part I.		acco use contribute to	
or Vital Records,	. 60 0	Completed						24a. Was ar autops perform 1∐ Yes 2	y prior to content?	opsy findings available ompletion of cause of 2 ☐ No
. Vit	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ 100	Hospital:	ent 2 ☐ ER/Outpatie	nt 3 DOA Oth		h (Check only one	nce 6 □Other (Spec	(6/)
	Logical Section of the section of th									
Division	or Attendation of Attendation of Director:	Certification:	2 Accident Investig	not be	ury - At home, farm, st c. <i>(Specify)</i>		res 2 No	28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or ii	th occurred at the tin	me, date and place, ppinion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ĭ	29b. Signature and title of certifie	1	7	29c. Licens	e number	_	d. Date signed (Month	Day, Year)
	Ž,		30. Name and address of person	who completed cause of de	eath (Item 23a) /Type	Print)	58/2	K	bowy 13	,200/
_	<i>Y</i> \			Bob 25 Mair			Reisters	stown,	MD 2113	6
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1	2007 3 Registra	ar's Signature	ne i				

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Item 27 is merked other then "naturel", or items 23a or other treumetic event, the Medical Exa⊞iner must be i or items 23a Baltimore, Maryland 21215-0036

William John Jankiewicz, Sr. 2007 9:35 P February 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Nursing Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 → M 2 ☐ F Months Days Hours Min Yrs March 19,1926 Maryland 219-16-7535 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Dundalk 1 ☐ Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States Funeral 1905 Quentin Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene.

Importent: If item 27 is merked other then "naturel", or item eny injury or other treumetic event. the \*\*L\*\*\*. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No ģ if Yes, Give Year or Dates: Specify Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel Industry 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie L. Hoffman ဥ Michael W. Jankiewicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland Sherry A. Timmons (Daughter) 758 221st Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 3/03/2007 Baltimore, Maryland 4□Donation 5 ☑Other (Specify)Entombment 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 2 a. Part1 Fund the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mode, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician phic myoto ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 SENSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2FTNo 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) tebruary 27,2007 william 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Ald 21204 Bint 6700 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

			For State Registrar	State of Ma	arylan		artmen rtificat			and M		giene Reg. No. 2	00	7 06197
	Physici /Medic		1. Decedent's Name (First, Middle, La Anna S		Jan	Liew	T				2. Date of De Month	ry 20	Year 200	J
	Examir Funeral	ner	4a. Facility Name (If not institution, gits a special Security Number 6.5)	yview medi		Center last birthday)	Bo If Under	1 Year	Location of	24 Hrs. T	8. Date of Birl	N th	/A	thplace (State or Foreign
	Director		215-18-9909 Usual Residence of Decedent	1□M 2XIF	95	Yrs.	Months	Days	Hours	Min.	April 9	9, 1911	Mar	yland
	ne Marylan Ba-f show ptified at	Director	MD 10b. County N/A		10c. Cit	y, Town or Lo	imore							10d. Inside City Limits 1 A Yes 2 No
	h with the 23a or 2 st be no	al Dire	10e. Street and Number 334 Gusryan Stre	et			10f. Zip	Code	2122	24		10g. Citizen	of What Co	ountry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2☐ N If Yes, Give Year or Dates:			Was Deced If Yes, spe 1 ☐ Yes			gin? (Spe 1, Puerto I	cify Yes or No Rican, etc.)	1	Race - Ame Black, Whit ecify.Whi	•
1215-0036	vithin 72 ho ne. han "natu e Medical	Completed	15. Decedent's Elementary/Secondary (0-12)		+)		kind of wo DO NOT u	rk done a se retired,	luring mos. )			16b. Kind o		·
land 21	should be filed wand Mental Hygies marked other tumatic event, th	To Be Co	8 17. Father's Name ( <i>First, Middle, Las</i> Joseph Schap	t)		Sewin	g мас	nine	18. Mothe	r's Name	(First, Middle,	Maiden Sur		Industry
, Maryland	and 2 shou ealth and M n 27 Is mar er traumat		19a. Informant's Name/Relationship		r						Route Number	-		Zip Code)
altimore,	0 0		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	20b. F	Place of Dispo emetery, crei	sition (Nar matory or d islau	me of other place S	e)	3/2/	07	20c. Location	on - City or imore	-
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice			6	224 E	aste	rn Av	enue	rles S Baltin	nore,		224
X	Physician /Medical Examiner		23a. Part Enter he distable, or cor shock, or heart fature. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as	rate a conseq	ory f	ailu		g, sucn as	cargiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death 2 days
8760,	sate be executed whysician and the burial-transit	dical Examiner	Sequentially list conditions, 1 chy, 2 ch 1 ch 1 ch 1 ch 2 ch 2 ch 2 ch 2 ch	cDue to (or as	- 2711									<u> </u>
.O. Box 6	t the death certific by the attending pached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes > No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 Feta	Ideath 3[	Ectopic pa Other (sp					23d.	Date of del Month	livery Day Year
Records, P.	w requires that been signed is should be det	by	Part II. Other significant conditions  (E) Thoracoplas	contributing to death by	tor (	ulting in the u	nderlying o	ause give	on in Part I.		23e. Did to			o the cause of death?
al Reco		Completed									24a. Was autor perfo 1∐ Yes		4b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of 2 No
or Vital	nysiclar nis certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 200 No	Hospital: 1 Inpatie	nt 2	ER/Outpatier	nt 3 🗆 DC	Othe	r.		(Check only only only only only only only only		Other (Spe	cify)
Division o	Attending Physician: r death. ector: After this certification of the funeral director; by the funeral director; is		27. Manner of leath  1 Natural 5 Pending  Accident investigation  3 Suicide 6 Could not I	20	Year)	28b. Time o Injury	М		at ? ∕es 2□		28d. Describe l	now injury oc	curred	
Divi	afte Dir	Certification:	4 ☐ Homicide determined	building, etc	c. (Specif	y) 					City or Tov	vn, State)		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical	(Check only 2 Medical Exa	hysician: To the best of the basis of and manner sta	examina	wiedge, deat tion and/or in	vestigation	at the tim i, in my of	oinion, dea	id place, a	ed at the time,	date and pla	ce, and due	to the cause(s)
	<b>7</b> wit		29b. Signature and title of certifier	h-20001										h, Day, Year)
	W		30. Name and address of person who	completed dause of d	1	aster	Print)	Phi	ie f	Sart	imove	rebru . Mr	) 21	26,2007 224
	Sta Regist	ate rar	31. Date fled (Month, Day, Year) MAR 0 1	2007 32. Fallstr	ar's Signa		Sec. S	7	1		. , , , , , ,	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** 10:00A M 28, George C. Keller February /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) New Jersey Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1X M 2□ F Months Days Hours 78 087-20-6339 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ¶Yes 2 No N/A Baltimore Director Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or USA 21207 2432 Pickwick Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1946 If Yes, Give Year or Dates: 1948 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: White Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Writer Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Keller Elizabeth Kickelhein ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2432 Pickwick Road Baltimore, Jane Keller, Wife Maryland 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/01/07 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evkemin montas **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2 **2**No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO SOLO 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: Hospital or Attending 24 hours after death. Injury 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in th 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) February 28 2007 29b. Signature and title of certifier 0

State Registrar

DHMH 17 Rev 1/2001

6701 N-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mon J- CHARLIES

MAR 0 1 2007

31. Date filed (Month, Day, Year)

Charles St Barme us 21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** SAMUEL. KING Feb 16 2007 7:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 130 Montgomery 8505 Springvale Rd Silver Spring If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 101 709-10-0756 1905 Catonsville MD Director 5 March Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show traumatic event, the Madical Experimental be notified at 1∰Yes 2 No Silver Spring Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 20901 United States #130 8505 Springvale Rd 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iten any injury or other traumatic event, the Musical Examin 1 ☐ Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ⊠ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Pullman Porter Railroad 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nellie Murphy George King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8667 Geren Rd Silver Spring MD 20901 Faye Adams/Niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition western Star 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-24-2007 Catonsville MD 1 4 ☐ Donation 5 ☐ Other (Specify) Cometery 22. Name and Address of Facility Ope Funeral Home 2) Signatur of Funeral Service Licensee 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 22 No 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING Md 20902 AVE # 116 9801 ANTHONY GEORGIA MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

	-	For State	State of	Marylan	-	artment of F rtificate of I				0 0 0 0 0 0 0
Physicia		Registrar     Decedent's Name (First, Middle, Land)		10 10 1				2. Date of De Month	Day Th	Year 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, gi	ve street and num			4b. City, Town, or		HERRUI	4c. Count	y of Death
		Northwest Hosp  5. Social Security Number 6.		ter 7. Age (In yrs.	last birthdav)	Randa11s		8. Date of Bir	Balt:	More  9. Birthplace (State or Foreign
Funeral Director		218-10-8792	1 <b>⊠</b> M 2□F	88	Yrs.	Months Days	Hours Min		, 1918	Couintry) MD
ow at	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
e mary	ctor	MD Balti	more	Gwy	ynn Oa	k				1 □Yes 2 No
a or 28 be no	Dire	10e. Street and Number 6825 Campfield R	d Ant	105		10f. Zip Code 2120	7		10g. Citizen of USA	What Country?
should be mad within 12 hours arier deatr with the inaryand the health Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Dece Armed For 1  Yes If Yes, Give	dent Ever in U. ces? 2[XNo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No rto Rican, etc.)		ce - American Indian, ck, White, etc. white
"natural", edical Exa	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gi	Year or Da ducation ade completed)	ites:	16a. Dece	dent's Usual Occup e kind of work done DO NOT use retired	ation	orking		gusiness/Industry
ygiene. ner than t, the M	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	1	raftsman			Kopper	
eve eve	To Be	17. Father's Name (First, Middle, Las Daniel Moses Kl	•				There	me (First, Middle, 25a	Maiden Surna Pin	· ·
f Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship Theoda M. Klotzm				ng Address (Street Campfield				, State, Zip Code) Oak, MD 21207
° = 5		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3   4 ☐ Donation 5 ☐ Other (Spec		State	Place of Disponentery, cre	osition (Name of matory or other place	- i	Date 3/2007		- City or Town, State
Department Important: any Injury once.		21. Signature of Funeral Service Lice		1-10-1		2. Name and Addre	ss of Facility Lo	ring Bye	ers Fune	eral Directors
nysician Medical xaminer the prival-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c. ART)	ROSE or as a conseq UTE P	uence of):	LOTIC C		MS LY LA	R D	Interval Between Onset and Death
attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2☐Feta ant at time of d	aldeath 3[	□Ectopic pregnancy □ Other (specify) _	,			ate of delivery onth Day Year
been signed by the should be detached	by	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did t		tribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
ate has bage 2	Completed							24a. Was autoj perfo 1∐ Yes		Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 风 No
After this funeral d	Certification: To Be	25. Was case referred to medical examiner?  1								rred
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical Ce			asis of examina		th occurred at the time time time time.				nanner as stated. , and due to the cause(s)
within To the compl	Me	29b. Signature and title of certifier	) W -	ehla	mo		11410		Februar	ed (Month, Day, Year)  y 28th, 20-v7
í) '		30. Name and address of person who was a man and address of person who was a man and address of person who was a man and address of person who was a man and address of person who was a man and address of person who was a man and address of person who was a man address of person who wad	1 C	1.0		Rain		P MEH		21133
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			1 - For State Registrar	State of	Maryla	nd / Depa <i>Cei</i>	artment of <i>tificate o</i> i	Health a f <i>Death</i>	and Me	ental Hygi	ene	7 06201
	Physic /Medi		Decedent's Name (First, Midd  JESSE CHAR	de, last) LES KRIDENO	FF. J	R.				Date of Death Month	Day Ye	3. Time of Death
	Exami		4a. Facility Name (If not institution	on, give street and numb			4b. City, Town,		of Death		4c. County of E	
		8	GOOD SAMARITA  5. Social Security Number		A //-			TIMORE			N/A	
	Funeral Director		217-12-3493	6. Sex 7. XX M 2□F	Age (In yrs	. last birthday) Yrs.	If Under 1 Yea Months Days		Min.	b. Date of Birth (Month, Day, 5/7/192	9. 3 M	Birthplace (State or Foreign Country) ARYLAND
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary First	ţ	MD BAL	TIMORE		PARKV						1 ☐ Yes 2 XNo
	th the	Director	10e. Street and Number			1 ALUXV	10f. Zip Code			100	g. Citizen of What	
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920	be filed within 72 hours after death with the Maryland Hygiene. I be Hygiene. I be Hygiene. I be Miscleral; or iteme 23s or 28s-f show event, the Miscleral Exercical result be notified at	by Funeral	Marital Status     Never Married 2	If Vac Give	s? XNo	lf	Vas Decedent of Yes, specify Cul ☐ Yes 2  No		gin? (Speci i, Puerto Ric	fy Yes or No- can, etc.)		merican Indian, /hite, etc. WHTTE
Ö O	72 ho	ted	15. Deceder	nt's Education		16a. Deced	ent's Usual Occu	pation		16	b. Kind of Busine	
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פ	e filed Il Hygi other vent, II	BeC	12TH GRADE 17. Father's Name (First, Middle,	Last)		5100	N CLERN	18. Mother	r's Name (F	First, Middle, Ma	STEEL	
<u>Ja</u>	5 2 2 5	ToB	JESSE CHARLES	KRIDENOFF,	SR.					AMMERBAC		
Maryland	C/ cg 'm 64		19a. Informant's Name/Relations			19b. Mailing	Address (Stree	t and Number	r or Rural R	Route Number, C	City or Town, State	e, Zip Code)
	1 and Health tem 27 other tr	3	WILLIAM KRIDEN	OFF/SON	201		ORTH REE	D ST.		AIR, MI		
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١.	lhainia		23a Part . Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one oddso on each	mio.	h. Do not ente	the mode of dyi	ng, such as c				Approximate Interval Between Onset and Death
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00	ng ph		IF FEMALE:									
	within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	I death 3 □E	ctopic pregnancy Other (specify)	/			23d. Date of d Month	elivery Day Year
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icien	certifi	00	25. Was case referred to medical examiner?	Hoopital: 3					of Death (C)	heck only one)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22.110
5	r this ral dir	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 X Inpati		ER/Outpatient 28b. Time of	3□ DOA Oth	4 U Nurs			6 □Other (Sp	ecify)
	ath. r: Afte e fune	atlor	Natural 5 Pending	g (Month, Da	ay Year)	Injury	28c. Injur Wor	yat k? Yes 2. □No		Describe how in	njury occurred	
2 4	er de	Certification:	3 Suicide 6 Could r	ned 28e. Place of In	jury - At ho tc. (Specify	me, farm, stree			28f.	Location (Street	and Number or F	Rural Route Number,
<u></u>	rai Di	ခ်ီ 								City or Town, Si	are)	
he Hoer	he Fune pletely fil	Medical	29a. Certifier Certifying One)	g Physician: To the best Examiner. On the basis of and manner st	n examinat	wledge, death o ion and/or inves	ccurred at the tin stigation, in my o	ne, date and pointon, death	place, and o occurred a	due to the cause t the time, date a	and manner a and place, and du	e to the cause(s)
Ę	Tot	Σ	29b. Signature and title of certifier	Anna			29c. License				Date signed (Mon	
	- 1	C4	> mmyn /				715	135		F	Brum	25,200
		J.	30. Name and address of person v	who completed cause of S WII MI	death (Item	23a) (Type, Pri	nt) LOCIF N	AVEN	Bu			, MD 21239
	State Registra		31. Date filed (Month, Day, Year) MAR 0 1		rar's Signat	ure like	BI					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #24a State of Maryland / Department of Health and Mental Hygiene
Per PHY G865 3/30/07tifHate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear 1645 CATHERINE KLOPP FEB 21 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA UNIVERSITY OF MED CENTER MARYLAND BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Days Hours Director 19,1959 186-54-7233 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo PA Myerstown Boro Lebanon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a U.S.A. 450 E. Main Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) 10th. Grade Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kirby Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Klopp 109 E. Reistville Rd. Myerstown PA20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02/27/2007 Fairview Cemetery Lebanon 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL **Physician** 14 DAYS /Medical Due to (or as a consequence of): **Examiner** BRAIN STEM HEMMORRHAGE 1 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown LUNG TRANSPLANT 2003 ANTITEYPSIN DEFICIENCY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed BOWEL PERF COLECTOMY death? 1 ☐ Yes 2 ☐ No C. DIFF COLITIS Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P1585 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene Street Baltimore, Maryland 20 Roberts 32. Resistar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 01 2007

			1 - State of M. State of M. Registrar		artment of Health a rtificate of Death		Hygiene Reg. No.	007 06	203
	8		Decedent's Name (First, Middle, Last)			2. Date of	f Death	3. Time o	of Death
, •	Physici /Medic		Marjorie Irene	Lamb		Month Fein	Day	Year 9:1	10 AM
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			Union Memorial Hospi		Baltimor			A/N	
	Funeral Director			e (In yrs. last birthday) 70 Yrs.	If Under 1 Year   If Under   Months   Days   Hours		Birth 28 36	9. Birthplace (State Country)	or Foreign
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside C	Nava I Januara
	flaryfa shoved at	ō	MD N/A	Baltin					s 2∏No
	the N 28a-i	Director	10e. Street and Number	Darcin	10f. Zip Code		10g. Citizen o	of What Country?	_
	3a or		1812 E. 31st Street		21218			USA	
	ms 2	Funeral	11 Marital Status 12 Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	gin? (Specify Yes or	No- 14. R	ace - American Indian,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. I had not nearly or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □  1 □ Yes 3 □  1 □ Yes 3 □	No	1 ☐ Yes 2 No Specify:		Spe	lack, White, etc.  cify:  Black	
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<u>g</u>	h ar h ar 7 Is		19a. Informant's Name/Relationship (Type. Print)  LaCelle Lamb-daughter		ng Address <i>(Street and Numbe</i> .3 Willshire				11206
_	s 1 and 2 of Health item 27		20a. Method of Disposition		osition (Name of matory or other place)	Date		n - City or Town, State	21206
altimore,	permit. Pages Department of I Important: If Its any Injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)	ory 3/2/	'07 Ba	ltimore	MD
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	107		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	I the death. Do not en				Approxima Interval Be	ite
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Box	death certif e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1□Live birth	2 Fetal death 3	⊒Ectopi <i>c</i> pregnancy			Date of delivery Month Day	Year
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2	that the ed by detac		Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.	23e. D	id tobacco use co	entribute to the cause of	death?
Records,	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	d by				1	☐ Yes 2 ☐ No	3 ☐ Probably	Unknown
S	w rec s beer shou	Completed				24a. W	/as an 24t	o. Were autopsy findings	available
Y Y	<b>sician:</b> The law certificate has b irector, page 2 s	omp				_ p	utopsy erform <b>g</b> d?	prior to completion of o death?	ause of
Vital		Be C	25. Was case referred to medical		26. Place	of Death (Check on		1 ☐ Yes 2 ☐ No	
	his D	To E	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	ent KER/Outpatier	nt 3 DOA Other: 4 Nu	rsing Home 5 R	esidence 6 □C	ther (Specify)	
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<u> </u>	ttend leath. ttor: / the fi	cati	2 Accident investigation	At home form at	M 1 Yes 2		772		
Division or	of or Attendate death Director: Director: A in by the f	Certification:	4 Homicide determined 200. Flace of Injury	ury - At home, farm, str c. (Specify)	eet, factory, office		n (Street and Nur Town, State)	nber or Rural Route Nun	nber,
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	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical	(Check only one) Medical Examiner: On the basis o and manner sta	f examination and/or in	vestigation, in my opinion, dea	th occurred at the tir	ne, date and place	e, and due to the cause(	s)
	To the within to the complex c	Ž	29b. Signature and title of certifler		29c. License number			ned (Month, Day, Year)	
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	N		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print) 2 Bill MO	212/1	\		
	Sta Registr			ar's Signature					
			1111 111		27.70				

07-01391 **UNK UNK** 

#### Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 05204 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 19, 2007 Lessane Medical Examiner Brian 1135 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Min Director 213-17-5797 11 87 MD 8  $_{1}XM$ 2 19 Country Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 X Yes 2 No Baltimore more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho Examiner must be notified at once. MD N/A Director 10e. Street and Number 10g. Citizen of What Country? USA 21213 Patterson Park Ave. 1534 N. uneral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married X No Yes "natural", or Specify: Black If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical is marked other than N/A unemployed 10th N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lessane tranmatic event, Be Dante Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1534 N. Patterson Park Ave. Balto., <u>Dante Lessane-mother</u> If item 27 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place 1 XBurial 2 Cremation 3 Removal from State MD 3/2/07 Baltimore Mt. Zion Cem. Donation 5 Other Specify: 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licenses MD1101 E. North Avenue Baltimore, I and ana 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ed by the attending physician detached for use as the burial certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. þ 1 Yes 2 No 3 Probably 4 Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes ✓ Yes 2 No 2 No certificate the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes After this 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Feb 19, 2007 Certification Subject shot 1112 hrs Natural 1 Yes 2 V No Pending the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 1 24 hours after α e Funeral Direc 28e Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 1000 block North Broadway, Baltimore , MD determined (Specify) Alley 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Within 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 20, 2007 0 7 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay, Year) egistrar's Signatur State 2007 CARLOS -Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #25,29a,29d, perMD, g805/3/1/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:20 PM Herbert Lawson 2007 February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins
5. Social Security Number Bayurew Medical Ctr. Baltimore N/A If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral 1** M 2□ F Months 52 Director 60 215 2864 OCT.31,1954 MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1√2Yes 2□No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or a 101 CENTER PLACE APT. 701 21222 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite wher traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11TH LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT LAWSON MARTHA ELLIE HUGHES ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fitem 2 other t JAMES LAWSON / BROTHER CHATFORD AVE. BALTO, MD. 21206 4622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any Injury or otl Burial 2 ☐ Cremation 3 ☐ Removal from State TRINITY CEM. 4 Denation 5 ☐ Other (Specify) FEB.14,2007 BALTIMORE,MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME mature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PRESTON ST. BALTO, MD. Immediate Cause (Final disease or condition resulting in death) Hepatic failure **Physician** 3 days /Medical Due ! (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Examine tany, leading to transcit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last + Chronic alcohol abuse The law requires that the death certificate be executed Chronic Hepatitis C

Due to (or as a consequence of): burial-trai attending physician for use as the burial INCO TO THE CONS. P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 21 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 □ Yes 2 □ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier adrien S. Janver, MD RES-000 February 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayuiew Medical Ctr, 4940 Eastern Ave., Balto., MD 21224

State Registrar Janvier

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For State Registrar	State of Marylar		artment of H			giene	7 06206
	× 10-		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia		Rett	y J. Lash				Februar	ry 21, 2	007 4:30 P M
•	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	r Location of D		4c. County	
		2	Washington Adventi			Takoma			Montg	
Ą	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Bin (Month, Da Oct. 16	th y, Year) 1923	Birthplace (State or Foreign Country)     Iowa
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Aaryla r sho	ō			,,	Brookev	#11a			1 ☐ Yes 2 No
	the N	Director	Maryland Montgomer  10e. Street and Number	<u>y</u>		10f. Zip Code	/IIIe		10g. Citizen of W	/hat Country?
	3a or	Ö	18824 Alpenglow L	ane		20	)833		United	States
	death	Funerai		2. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin' an. Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Race	e - American Indian, k, White, etc.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural; or itams 23a or 28a-f show aumatic event, the Medical Executar mint to notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 No	Specify:		Specify:	
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Maryland 21215-0036	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)  Cecil Arthur					Name (First, Middle, nsy Gerare		θ)
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Mai	O: (G == =		19a. Informant's Name/Relationship (Type Byron W. Lash/Son	e, Pnntj				r Rural Route Number		Virginia 20165
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nor	Pages nent of I int: if it		1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	moval from State A1	Ting to	n Nationa n Nationa		rch 13,	Arlingt	on, Virginia
Baltimore,	permit. Pages Department of the Important: If ite any injury or of		21. Signature of Funeral Service Licensee	e	Cemet	2. Name and Addre		ey Funera	1 Home /B	ethesda-Chevy
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	rted Insit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DEED VI	ENOUS	T242)6	MBOS	1 6		WEEVS
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9	artifica ing ph e as ti		IF FEMALE:							
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregr	al death 3[	Ectopic pregnancy	/		23d. Date Mor	e of delivery nth Day Year
P.0.	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	deam 5L	Other (specify) _				
	that the by detact	y Ph	Part fl. Other significant conditions cont	inbuting to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contr	ribute to the cause of death?
ds	w requires that the de been signed by the s should be detached	d be	CORONARY	BYPASS	FER	BRUARY	2,20	07 10	Yes 2□No	3 Probably 4 Unknown
000	law red as beel 2 shou	Completed	LAPARDSCOPIC.	CHOLECYST	ECTON	LV FEB	RUARY	1 24a. Was	an 24b. V	Were autopsy findings available
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	th		30. Name and address of person who cor				/₁∩ Tal-	romo Dowl-	Mazzzlas	ad 20912
	Sta	ate	Thomas Militano, M. 31. Date filed (Month, Day, Year)	32. Regisfrar's Sign		venue #44	+∪, 1ak	koma Park,	narytan	IQ ZUTIZ
	Regist		B n n n n	2007	le	1-0				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	arylan		artment of F		nd Mental Hy	giene	07	06207
	Physici	an	1. Decedent's Name (First, Middle, Arthur Wright						2. Date of De	_	ž867	3. Time of Death 7;30 P M
	/Medic Examin		4a. Facility Name (If not institution,		)		4b. City, Town, or	r Location of		4c. County		7,50 F W
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	Funeral		,	5. Sex 7. Ag 1. ★ 2 ☐ F	ge (In yrs. I	ast birthday Yrs.		If Under 24 Hours	Min. 8. Date of Bir	, Year) 922	9. Birthpla	ace (State or Foreign
	Director		216-20-7346 Usuat Residence of Decedent		U-1				оср. 2.	, 1722		rgia
	arylan ehow	_	10a. State 10b. County	1 • 1	10c. City	r, Town or L					10	d. fnside City Limits
	the Ma	Director	MD Fr	ederick			Hagerstow	n		10a Citizan et V	V/5-14 C	1 ☐ Yes 2√ No
	3a or	iDir	16938 Shinham R	~ ~ d				40		10g. Citizen of V		•
	deeth	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of H		in? (Specify Yes or No Puerto Rican, etc.)	United 14. Race	e - America	in Indian,
9	filed within 72 hours after deeth with the Maryland Hygiene. Sther than "natural", or Iteme 23a or 28a-f ehow ent, tra Medical Examinar must be notified at	by Fu	1 Never Married 2 Married	d 1 ☐ Yes 2 ☑ ff Yes, Give			1 Yes 2 No	Specify:	ruello filcati, etc.)		k, White, e Whi.t	
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Baltimore, Maryland 21215-0036	e d ia	Be	17. Father's Name (First, Middle, La Russell E. Macor	•					s Name (First, Middle, elyn M. Dav		e)	
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S	1 and 2: Heelth ar tem 27 ie		Kathie Boyce - o	daughter					Hagerstown	=		
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Bai	permit. Pages Depertment of I Importent: If its eny injury or o		Sulle V	I l	1012	N // /	2. Name and Addres		Ambrose Fing Rd., A	Tuneral I Arbutus,	Home, MD 2	Inc. 1227
			20a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	d the death ine.							Approximate Interval Between Onset and Death
J. Salah	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)		ner							Onset and Death
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687	the the	edicai		d								
Вох	leath certific attending p	an/M	tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome 1 ☐ Live birth	of pregnar		Ectopic pregnancy				e of deliver	•
0	0 00	Physician/Me	1 Yes 2 No	4☐Pregnant at 9☐Unknown	t time of de	eath 5[	Other (specify)	<u> </u>		Mor	ıın ı	Day Year
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ğ	v require been sig should b		- Metastati	c Prost	ale	Ca	ncer		101	res 2□No	3 🗌 Proba	bly 4 □Unknown
Vital Record	> 0 0	Completed	- Atrial Fil	smillah	non				24a. Was	sy p	rior to com	sy findings available pletion of cause of
<u>a</u>	icien: The lav certilicete has rector, page 2								1 ☐ Yes	2 No 1	leath?	2□ No
	rsicien: s certilic director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospitat:	ent 2 🗆 F	=R/Outnatie	nt 3 DOA Othe		if Death (Check only o		or (Conside)	
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Division of	± 5 €	Certification:	4 Homicide determine	ed 28e. Place of tri building, et	fury · At hot tc. (Specify	me, farm, st	reet, factory, office		281. Location (S City or Tox	Street and Number vn, State)	er or Rural	Route Number,
	To the Hospital (within 24 hours a To the Funeral Completely filled i	edicai	29a. Certifying (Check only one)  2 Medical Ex	Physician: To the best caminer: On the basis o and manner st	of examinati	vledge, deat ion and/or in	h occurred at the time vestigation, in my op	ne, date and pinion, death	place, and due to the occurred at the time.	cause(s) and mar date and place, a	nner as sta and due to t	ted. the cause(s)
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1	0		Hemen Shall	1,65 CT	ham	asT	ohnsor	Dr	Frede	wice	MS	21702
	Sta Registr		31. Date filed (Month, Day, Year)  MAD 0 1	32. <b>Pogistr</b>	ar s signat	K A	19480					

			For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygier	2007	06208
	Physici	an	1. Decedent's Name (First, Middle, Last)	9.4	1		Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		4b. City, Town, or Location of De	February	27 2007 4c. County of Death	12 1
	Examin	er	LINION MEMOR	1AL HOSPITAL	BAITI	MORE	AC. County of Death	4
	Funeral		5. Social Security Number 6. Sec	//	Months Days Hours Mi	rs. 8. Date of Birth (Month, Day, Ye	9. Birth	pplace (State or Foreign intry)
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or		19AY 10, 1	110 000	THCAROLINA
	be filed within 72 hours after death with the Maryland hat Hygliene. ed other then "natural", or Items 23a or 28a-f ehow event, it a Madical Esaminar must be notified at	tor	10a. State 10b. County	1A	BALTIMO	RE CIT	V	10d. Inside City Limits 1 X Yes 2 □ No
	vith the	Funeral Directo	10e. Street and Number	1-0 Page	10f. Zip Code	10g.	Eitizen of What Cou	ıntry?
	ns 234	erai	1002 ANDOV		3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer	ncan Indian,
_	or Item	by Fun	1 Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes. Give	If Yes, specify Cuban, Mexican, Put  1 Yes 2 No Specify:	erto Rican, etc.)	Black, White	, etc.
8	72 hours after natural', or Ite	ted b	3 Widowed 4 Divorced  15. Decedent's Edu		cedent's Usual Occupation	16b	. Kind of Business/li	ndustry
21215-0036	within 7: ene. then "n	Completed	(Specify only highest grad	College (1-4or 5+)	ive kind of work done during most of wear. DO NOT use retired)	OVE D	relamen =	100
	Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	2	18. Mother's N	lame (First, Middle, Maid	ten Sumame)	ION COI
Maryland	should be nd Mental marked o	To B	JACOB	MCCAN	ITS IRE	NE	GRIFF	EN
Mar	s 1 and 2 should f Health and Mer item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Ty HENRIFTTA MCC	PANIS (WIFE) 100	ailing Address (Street and Number or a	Rural Route Number, Cit PD BD 7	y or Town, State, Zi	ip Code) 1 2/2/7
ore,	of Hea		20a. Method of Disposition  1.0 Brottal 2 Cremation 3 F	20b. Place of Dis	sposition (Name of crematory or other place)	Date 20c.	. Location - City or T	own, State
Baltimore	Pag nent snt: I		4 Donation 5 ☐ Other (Specify)	() MMT, Z		-07-07 L	47500 WA	E, MD
Bal	permit. Departm Imports any inju		21. Sunature of Funeral Service Licens	6. Loane	22. Name and Address of acility	BROWN C	RIFUNE BAITO, M	PRAL HOME
			23a. Part1. Enter the disease, or complete thock, or treat failure. List only of	ications that caused the death. Do not one cause on each line.	enter the mode of dying, such as card	iac or respiratory amest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Heart Failure	,		Onset and Death  5 Veors
1	Examiner		Convention to the secondary	۷		10 years		
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
Ć.	te be executed ysicien and te burial-transit	Examiner	that initiated events resulting in death) Last					
8760		dicai	(	1				
Box 6	deeth certifica le attending pt ed for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	205-1		23d. Date of deliv	/өгу
.O. B	the atte	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
<u>α</u>	res thet the digned by the be detached	by Ph	Part II. Other significant conditions co.	ntributing to death but not resulting in the	23e. Did tobacc	23e. Did tobacco use contribute to the cause of death?		
ords	w require been sig should b					1 Ves	2 No 3 Pro	bably 4 Unknown
Rec	The law requires thet the ate hes been signed by th page 2 should be detache	Completed				24a. Was an autopsy performed	2/ prior to co	opsy findings available ompletion of cause of
ital		Be Co	25. Was case referred to medical		26. Place of D	1 ☐ Yes 2 ☐ Heath (Check only one)	No 1 □ Yes	2□ No
> ¥	Physicien: this certific ral director,	ToE	1 Tes 2 1 140	lospital: 1 ☑Inpatient 2 ☐ ER/Outpat		Home 5 Residence		ify)
ono	fing After fune	tion:	27. Manner of Death 1. □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how in	ijury occurred	
Division of Vital Records,	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, St		
	Hospitel 24 hours a Funerai D tely filled i		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, de	eath occurred at the time, date and pla	ce, and due to the cause	s(s) and manner as	stated.
	the Ho hin 24 the Fu mpletel	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death oc	curred at the time, date a	and place, and due to	to the cause(s)
	o Twit		29b. Signature and title of certifier B	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.  Completed cause of death (Item 23a) (Typ. D. O. Whion Med. 32. Registrar's Signature	AT243894	6 Fe	buay 2	27,2007
	27		30. Name and address of person who co	ompleted cause of death (Item 23a) (Typ	pe, Print)	MD		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	morios Hospisa	/ 4-1 1		
	Regist		MAR 0 1 20	107 Barres St. A	pads			

			For State Registrar		State of	Maryla		artment of rtificate o			lental		C. U (	7	06209
1. Decedent's Name (First, Middle, Last)							Dodin		2. Date	of Death	. No.		3. Time of Death		
	Physici		John	А	M	oore					Mont	h	Day	Year	5:10а.м
	/Medi		4a. Facility Name (If not insti					4b. City, Town	or Location	of Dogsth	2	26	200		
4	Examir	ıer											4c. County		
_			Joseph 1  5. Social Security Number				s. last birthday)	If Under 1 Yes	timor		0.5	(0)	1	N/A	
	Funeral			0. 5	iex □XM 2□F	52	s. rasi birinday) Yrs.	Months Day		Min.		th, Day, Y		9. Birth	place (State or Foreign ntry)
	Director		214-62-7583 Usual Residence of Deceden	)							5	27	54	M	D
	and *		10a. State 10b. Co			10c. 0	City, Town or Lo	cation							10d. Inside City Limits
	farylan	5	MD	N/	λ		Baltim	0.10.0							1. Yes 2 □ No
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	Mith of Mith	Director	10e. Street and Number					10f. Zip Code				100	. Citizen of V	Vhat Cou	ntry?
	ours after deeth with the Maryla rai', or itame 23a or 28a-f shov Examinar must be notified at	Funeral	2915 Edge	ecom					1215				US		
	itama i	Tue	11. Marital Status		12. Was Deced	dent Ever in ces?	U.S. 13.	Was Decedent of f Yes, specify Ci	f Hispanic Ori uban, Mexicar	gin? (Spen, Puerto	ecify Yes Rican, etc	or No-		e - Ameri k, White.	can Indian, etc.
36	ori		1 Never Married 2		1 ☐ Yes	2 <b>⊠</b> No ∋	1	1□ Yes 2□X					Specify		
21215-0036	72 hours after deeth with the Maryland natural, or Itama 23a or 28a-f show dical Examinar must be notified at	Completed by	3 XWidowed 4 □ Divo		Year or Da	tes:							Opera,		lack
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p	m - 0 5	Be	17. Father's Name (First, Mic	idle, Last,	)				18. Mothe	er's Name	(First, M	liddle, Ma	<i>iden Suma</i> m	Θ)	
<u>la</u>		2	Bert			Moor	e		W	oolr	idge	е		A	dams
Maryland	s 1 and 2 should f Health and Mer itam 27 is marks other traumstic		19a. Informant's Name/Rela											State, Zij	Code) 21215
	1 and 2 Health tam 27		Yvonne M.	Ерр.	s-siste	er	291	5 Edge	combe	Cir	cle	Nor	th Ba	lti	more, MD
Baltimore,	of Hea of Hea fitam		20a. Method of Disposition			20b.	Place of Dispo	sition (Name of	(aca)	C	ate	20	c. Location -	City or T	own, State MD
Ę			1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			itate (	Cedar	natory or other p Hill C	em.	3/3/	07		Anne	Aru	ndel Co.
≢	permit. Pag Depertment Important: I any injury o	1	21. Signature of Funeral Ser					. Name and Add	Iress of Facilit	v					
Ba	permit. Pag Depertment Important: I any injury o		Mea	2	0 47	0	-			^ MA	RCH	FUN	ERAL	HOM	E-EAST
	_		23a. Part1. Enter the diseas	e or com	nlications that ca	used the de								re,	MD 21202 Approximate
и			snock, or neart failure.	List only	one cause on ea	ch line.	1 1.	i ii	ying, such as	Cardiac	respirati	ory arrest			Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	1000	a	meta	static	lung	Cano	oV					4cars
	/Medical Examiner		resulting tri death)	•	Due to (a	or as a conse	equence of):	1							
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o,	en a rial-1	Ä	resulting in death) Last	-	Due to (o	r as a conse	quence of):								
8760,	cate be executed physicien and the burial-transit	dlcal			d										
9		ed											1		
Вох	death certific e attending p d for use as	2	IF FEMALE: 23b. Was decedent pregnan		23c. If yes, outc	ome of pregr	nancy						23d. Date	of delive	erv
m	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No			th 2□Fet nt at time of		Ectopic pregnant Other (specify)	су				Mon		Day Year
O.	the che	Physician/Me	9 Unknown		9□ Unknov	wn		(							
Φ.	law requires that es been signed b 2 should be deta		Part II. Other significant cor	ditions o	ontributing to dea	th but not re	sulting in the ur	derlying cause o	oven in Part I.		23e.	Did tobac	co use contri	ibute to the	ne cause of death?
ds	sign d be	d by			_		-	, ,						3 Frot	
Ö	w requir been si should	Completed							-				20.10	B	
ec	e law hes t	du									1	Was an autopsy		vere auto	psy findings available mpletion of cause of
=	pag pag	Cor									1 🗆 Y	es 2	No 1	eath? □ Yes	2 No
ita	Physician: This certificeral director, p	Be	25. Was case referred to me examiner?	dical					26. Place	of Death					3
<u></u>	nysic nis ca dire	2	1 ☐ Yes 2 No		Hospital: 1 In	patient 2	☐ ER/Outpatien	3 DOA C	ther: 4 Nu	rsing Hon	ne 5	Residenc	e 6 the	r (Specif	Hospice
0			27. Manner of Death		28a. Date of	Injury Day Year)	28b. Time of Injury	28c. lnj	ury at ork?	2	8d. Desc	ribe how	injury occurre	ed	
Division of Vital Records,	Attending r death. actor: After y the fune	atic	1 Natural 5 ☐ Pe 2 ☐ Accident in	nding estigation		, 24, . 64,	Migary		∐Yes 2 ☐ N	No					
<u>Ş</u>	or Attenated or Attenated or Attenated or Incorporate Original Incorporate	ertification;		uld not be termined	28e. Place o	of Injury - At I	home, farm, stre	et, factory, office	9	2				r or Rura	l Route Number,
	a after	Cert	TIOMICIOS		bullang	g, etc. (Spec	ny)				City o	r Town, S	tate)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Cert	itying Ph	ysician: To the b	est of my kn	owledge, death	occurred at the	time, date and	d place, a	nd due to	the caus	e(s) and mar	ner as s	ated.
	P Ho	edical	(Check only 2 Mad one)	ical Exan	niner: On the bas and manne	sis of examin	ation and/or inv	estigation, in my	opinion, deat	h occurre	d at the t	ime, date	and place, a	nd due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and little of ce	rtifier					nse number			29d.	Date signed	(Month,	Day, Year)
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	j,		30. Name and address of per	son who	completed cause	of donth /!-	m 22a) (Tues 1	Print\	ν .			Te	ny wary	10	, 200/
	И		Ten Int	10:	Apripreted cause	Or Geath (Ite	111 23a) (1ype, 1	PALE	tata	CI	Ω	16	, , ,	ID	21201
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			4111 11 7		1000	Liver of	100	E-Size							

**Physician** /Medical Examiner

**Funeral** Director

r 28a-f show notified at ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other i injury or

Maryland 21215-0036

Saltimore,

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 23:15 4. Morgan February 21 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death C17 Hopkins Hospital Baltimore Johns 8. Date of Birth (Month, Day, Year) 9 3 1945 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 1**№** M 2□ F Days 217-40-6899 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XXYes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1702 N. Port Street 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
N/A Maintenance Engineer Garrett Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Morgan Gracie Murrill 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1702 N. Port Street Baltimore, MD 21213 Margaret V. Morgan-wife 20b. Place of Disposition (Name of gemetery, crematory or other place)
King Memorial Pk. 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/28/07 MD Randallstown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Inda wane 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 hours severe sepsis Due to (or as a consequence of): small cell carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Szalarny, Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MD. OLGA SZALASNY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Month Physician Lillian Myles connen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agres imore N/A Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number **Funeral** 1 □ M ½ X F Yrs. Director 217-26-5776 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 1 √ Yes 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2703 Mura Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status nit. Pages 1 and 2 should be filed within 72 hours after arment of Health and Mental Hygiene. ortant: if Itam 27 is marked other than "natural; or ite injury or other traumatic event, Itam Mudical Exturning. 1 Yes **X**(**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ð 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th Colfege (1-4or 5+) N/A Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Sally Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2703 Mura Street Baltimore, MD 21213 Celess Myles-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk. 2/28/07 MD Randallstown 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 1 lad waner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Baltimore, MD 21202 Approximate Interval Between Onset and Death fmmediate Cause (Final Physician Pheumonia INKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, funeral director, page 2 should be LLrosepsis 1 Yes 2 No 3 Probably 4 Thknown Be Completed Cerebrovascular 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient → Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To After this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Ratural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funaral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1) Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiful Don533/2

Registrar

DHMH 17 Rev 1/2001

900 caton Avenue; Baltimore, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hengseler

2007

imp

32 Registrar's Signature

Michelle

31. Date filed (Month, Day, Year)

MAR

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MORRIS FEBRUARY 18.10 DEANNA 2007 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYWEW MEDICAL CTR BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🖾 F 35 213-13-3051 Director July 21,1971 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Dundalk Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with a or "natural", or items 23a 21222 321 A Wise Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 12 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Years Paralegal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Donald L. Morris Marion V. Tollberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Mr. Donald L. Morris (Father) 2020 Kelmore Road Dundalk, Maryland 21222 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages 1
Department of H
Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem: 2/28/2007 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Lie as a stringery Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 1 Tyes 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 은 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation ours after death.
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filled in by the fu death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D RES 000 20 EBRWARY 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n 4940 EASTERN AVENUE, BALTIMORE, MD 21224 DROLUWASEUN FALADE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Grace Edna Merkle 7:30 P M February 27,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Care Ctr. Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 🖼 F Director 83 June 13,1923 219-10-8504 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County If item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at Parkville 1 ☐ Yes 2x No Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 death 2915 Garnet Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Tho If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Inportant: If itam 27 is marked other than "naturel", or itas any injury or other traumatic event, the Medical Examinations. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Drug Store Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna J. Johnson John B. Merkle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkville, Maryland 21234 2915 Garnet Road Mr. Gerald Merkle (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3/1/2007 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature A Sineral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

Immediate Cause (Final 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death **Physician** NEUMORIF disease or condition resulting in death) /Medical Examiner Sequentially list on altions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the ettending physicien and dbe detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 25 No 24a. Was an certificate has b lirector, page 2 s autopsy 1 Yes 210No Division of Vital To the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕡 🗸 6 ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) n 11000 Registrar's Signature State 2007 Registrar

Maryland 21215-0036

Phys /Mo Exa

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28a-1 ehow eny injury or other treumatic event, the Macical Examinar must be notified at Physici /Media Examir

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of	Maryland / I		ment of F iicate of i		Mental Hy		base	7 06214			
		1. Decedent's Name (First, Middle, Last)  2. Date of Death												
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Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								4c. County of Death				
		GENESIS ELDER 5. Social Security Number		Age (In yrs. last bi	inthday) If	PARKV Under 1 Year	ILLLE If Under 24 Hi	rs. 8. Date of B		BALTI	9. Birthplace (State or Foreign			
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M H		10a. State 10b. Count	10c. City, Tow	vn or Locati	on			10d. Inside City Limits						
a-f eh	ctor	MD BALTIMORE LOCH RAVEN VILLAGE									1 ☐ Yes ZA No			
or 28	Director	10e. Street and Number			10f. Zip Code						10g. Citizen of What Country?			
230		8157 GLEN GAF		21234						USA				
Important; if item 27 is marked other than "natural", or iteme 23e or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma  3 ☒Widowed 4 □ Divorce	ent Ever in U.S. es? [XNo	If Yes, specify Cuban, Mexican, Puerto					Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE					
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)		30. Name and address of person who completed cause of clear (Item 23a) (Type, Print) 57 (202 Butti Mine 2/204												
Sta Registr		31. Date filed (Month, Day, Yea MAR 0	1 2007	jistrar's Signature	Sin	was 9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-01583 Bertha Mark

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State C6	ertificate of D	eath		Re	eg. No.	0:00=:
Physicia	ysician/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death Mooth Day Y							3. Time of Death
Medical Exami		Bertha L. Mark			1447 hrs			
		Facility Name (if not institution, give street and number)     A14 North Haven Street		City, Town, or Li altimore	ocation of Dea	arn	4c. County of	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday) If	Under 1 Year	If Under 24	Irs. 8. Date of Bir	N/A	9. Birthplace (State or
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	Σ	29b. Signature and title of certifier		29c. License				(Month, Day, Year)
		Theodor M. King Thy m	un.	O.C.M	l. ⊏.		February 27,	, 2007
V		30. Name and address of person who completed cause of death (Ite Theodore M. King, Jr., MD. Assistant Medical		1 Penn Stre	et Baltimo	ore, MD 21201		
	tata	Theodore M. King, Jr., MD. Assistant Medical  31. Date filed (Month, Day, Year)  32. Registrar's Signa		T GIII SUE	or, Damin	5, 6, IVID Z IZU I		
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	Physicia /Medic		Darlene E. Nemec February 27 2007							
)	Examin	er	4a. Facility Name (If not institution, give street and number)  SAINT AGNES HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death					
All was	Funeral		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Cour							
h	Director		214-56-6322 56 Yrs Usual Residence of Decedent	10/08	/1950 Maryland					
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	the Ma 28a-f s notified	Director	MD Carroll Fink  10e. Street and Number	sburg 10f. Zip Code	1 ☐ Yes 2 ★ No  10g. Citizen of What Country?					
	h with 23a or st be r		3810 Frieda Drive	21048	United States					
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Bal	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hubbard 4107 Wilkens Avenue, Bal	Funeral Home, Inc. timore, Maryland 21229					
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death					
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% 68	leath certifica attending ph I for use as t	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy		Old Date of delivery					
Box	death death death death	ician	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Yes 2 ☐ No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year					
P.0	The law requires that the death certificate be the bear been signed by the attending physicis age 2 should be detached for use as the bu	Physician/Medical	9 □ Unknown 9 □ Unknown	o undedular seuse sines in Port I	dahaan uu aantiib da ka ka aa aa aa aa ah a					
	signed d be de			, ,	d tobacco use contribute to the cause of death?  ☐ Yes 2☐ No 3☐ Probably 4 ☑ Unknown					
Records,	tw require s been significations should to	Completed by		24a. Wa	as an 24b. Were autopsy findings available					
I Re		Somp		au' pe 1∐ Yes	topsy prior to completion of cause of death? 1 □ Yes 2 □ No					
Vital	sician certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only						
or	g Physer this	n: To	1 Inpatient 2 EH/Outpa	e of 28c. Injury at 28d. Describ	sidence 6 Other (Specify) e how injury occurred					
sior	tending Feath.	atio	1 ✓ Natural 5 ☐ Pending (Montin, Day Year) Inju	M 1 ☐ Yes 2 ☐ No						
Division	Hospital or Attending 14 hours after death. Funeral Director; After tely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)					
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical (		eath occurred at the time, date and place, and due to the rinvestigation, in my opinion, death occurred at the time	re cause(s) and manner as stated. e, date and place, and due to the cause(s)					
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	. 0		30. Name and address of person who completed cause of death (Item 23a) (Ty	P 06 06 2	7ebruary 27,2007					
	10		900 CATON AVENUE BAL		11229					
T.	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A						
DH	MH 17 Rev 1/2	-	MAR 0 1 2007							
,			0	RIGINAL						

			State of Maryland / Department of Certificate o	f Dooth	ene 2007 06217
	Physici	an	1. Decedent's Name (First, Middle, Last)  MARY R. PILKERTON	2. Date of Death Month	Day Year 3. Time of Death 24, 2007 5: 32 A M
	/Medio Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town PLEASHAT VIEW NURSING HOME 4101 OLD NATIONAL PIX F  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 yes	ar If Under 24 Hrs. 8. Date of Birth	4c. County of Death  ARROLL  9. Birthplace (State or Foreign
L	Director		216−16−2176   1 M 2 XF   83 Yrs.   Month's Day Usual Residence of Decedent	Oct 10	1923 MD
	f show	ō	10a. State   10b. County   10c. City, Town or Location   MD   Carroll   Westminster		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	10ç	g. Citizen of What Country?
	sath wi	erai [		21157 f Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
920	ors after de el', or Itam Examinent	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give Arear or Dates:	uban, Mexican, Puerto Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Evaluation must be notified at anone.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ne during most of working ired)	6b. Kind of Business/Industry
	il Hygie other	Be Co	17. Father's Name (First, Middle, Last)	etary  18. Mother's Name (First, Middle, Ma	Clerical  siden Sumame)
ylar	ould by Menta larked	To E	Charles Constantino	Harriet Ane	•
Maryland	nd 2 sh lith and 27 is rr r treurr		Mr. Richard Schultz (Personal Rep) 203 Drumca	et and Number or Rural Route Number, Castle Ct Wastmins	
ore,	ges 1 au t of Hea lf item or otha		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p	place) Date 20	0c. Location - City or Town, State
Baltimore,	artmen artmen ortant: injury		. 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Add		ykesville, MD
B	Depariment of the control once.		Duan C. Haight Sykesvil	uneraliiy HOME & CHAPE Le, MD 21784 (410)-	L, PA (Box 195) 795 <del>-</del> 1400
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ying, such as cardiac or respiratory arres	t, Approximate Interval Between Onset and Death
68760,	examiner  nysician and he burial-transit	edicai Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	che lung de	some yours
P.O. Box (	ires that the death certific. signed by the attending pl d be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	iaw raquires that the as baen signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause		cco use contribute to the cause of death? 2  No 3  Probably 4 Unknown
Il Records,	The law raqu sate has baen page 2 shoule	Completed	Congodine Nearly Failure	24a. Was an autopsy performe	
Vital	siclen: certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death (Check only one)  Other: 4 ✓ Nursing Home 5 ☐ Residence	on 6 Dother (Specific)
Division of	Attending Physiclen: r death. ector: After this certification of the funeral director.	tion; To	27. Manner of Death 28a. Date of Injury (Month, Day Year)  1 ☐ Matural 5 ☐ Pending (Month, Day Year)  1 ☐ Matural 5 ☐ Pending (Month, Day Year)		
Divis	al or Attend s after death of Director: A td in by the f	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physiclen: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the composition of examination and/or investigation, in my and manner stated	y opinion, death occurred at the time, date	and place, and due to the cause(s)
	1	M	29b. Signature and title of certifier  We was Stroke and Stroke an	0 6 5 8 8 29d	1. Date signed (Month, Day, Year)  2 2707
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Philipson VIII)	21)1CON COL	٩' /
	Sta * Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAR 0 1 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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ing species	- Caller	100	-	4.00		D. S. College	-

		l-For State Registrar		C	ertificate	of L	Death			R	teg. No.	Time Set 1	2 3	
Physicia	ın/	Decedent's Name (First, Midd								Date of Dea	ath	Year		ime of Death
Aedical Exami		Day			lk	T 41.	01 7-			Month February				306 hrs
		4a. Facility Name (if not institution 837 N. Fulton Avenue	_	umber)			. City, Town, or t Baltimore	Location o				N/A		
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthda	y)	If Under 1 Year Months Days			8. Date of Bi	rth (MM/D		9. Birthplac oreign	ce (State or
Director		219-40-0086	1 M 2 F	61		Yrs.	Months Days	Hours	IVIII I.	8 1	5 19	945	Country)	MD
ž:	-	Usual Residence of Decedent  10a. State 10b. County		100.0	itv. Town or L	ocation	1		_				10d.	Inside City Limits
ow any			/ 7											X Yes 2 No
Maryland 28a-f show d at once.	핡	MD N,	/ <u>A</u>		Balti		e 10f. Zip Code			12	IOa. Citize	n of What		
th the Maryland 23a or 28a-f sho notified at once	Director	lll Park Av	zenne				2120	7	USA					
with the is 23a e noti		11. Marital Status		cedent Ever in	n U.S. 13		Decedent of Hisp	oanic Orig			D- 1	4. Race - A		ndian, Black,
leath '	Funeral	1 XXNever Married 2 M	arried Armed F	orces?	0	If Yes	, specify Cuban,	Mexican,	Puerto Ri	can, etc.)		White, e	etc.	
after c	by F		orced if Yes, Give Ye	ar				specify:				pecify:		
hours natur Sxam	ed	15. Decedent's Education (Spe			l) 16a. Dec		Usual Occupation of working life.				16b. Kir	nd of Busin	ess/Indust	try
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use unknown N/A Disabled   17. Father's Name (First, Middle, Last)   18. Mother's Name (Firs											N/A	4	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)								s Name (F	irst, Middle,	Maiden S			
									Mami	e		Sc	crug	ns
21215 ould be fill d Mental H s marked		19a. Informant's Name/Relations		_	19b. M	lailing A	ddress (Street	and Num	ber or Rur	al Route Nu	mber, City	or Town,	State, Zip	Code)
and 2 should be filealth and Mental tem 27 is marked traumatic event,		Lauren Siegel	l-social			11	Park A	veni	ue B	altim	ore	MD	21	201
ore, MD 2 es 1 and 2 shou of Health and I fitem 27 is n her traumatic		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal f	from State	Db. Place of D crematory	or other	on (Name of cerr r place)	netery,	١	Date (0	20c. Lc	ocation - Ci	ty or Town	
		1 Burial 2 Cremation 4 Donation 5 Other S		S						/28/0	Ba	altin	nore	MD
Baltimore, Dermit. Pages I at Department of He Important: If ite		21. Signature of Funeral Service	Licensee	_			ne and Address		LIA	RCH F	UNEF	RALI	IOME-	-EAST MD 2120
	-	23a. Part I. Enter the disease of	complications that	caused the de	eath. Do not e									proximate Interval
Physician		failure. List only one cause	on each line.										Be	etween Onset and Death
£xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			araio	VAGCUIAI DIS	Cuoc					$\neg$	
		Sequentially list conditions,	b										_	
	Ē.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequent	ce of):									
T 11	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):			- <del>*</del>						
760, icate be executed physician and the burial - transit	ä.		d	<del></del> _									_	
rial ci e e	/Medical	UNPENDED	AMENDED				-				234	Date of de	livery	
		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		, outcome of p birth		Fetal	Ideath 3	Ectopic	pregnanc	у		fonth	Day	Year
Sox 687 leath certiff e attending for use as t	Sici		line and	nant at time o	of death 5	Othe	r (Specify)				-			
the der	Physician	Part II. Other significant condi	9		not resulting in	the und	derlying cause g	iven in Pa	art I.	23e. Did 1	obacco us	se contribu	te to the c	ause of death?
P.O. s that the gned by t	ρ	Seizure Disorder; Ch			J		, , ,			1 Ye	s 2	No 3	Probably	4 🗸 Unknown
Division of Vital Records, P.O. rat or Attending Physiciau: The law requires that the rs after death.  "a Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed									24a. Was				findings available etion of cause of
COF e law r e has t	d m	<del></del>			-						ormed?	dea	ith?	2 No
Rec The liftcate or, page	ပ္ပ	25. Was case referred to medical	91				26.Place	of Death	(Check on		2		Yes	2 110
Vital F ysiciau: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outp	atient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residen	ce 6 🗸	Other: Sce	ne
1 of V ding Phy.	-	27. Manner of Death	28a. Dat	e of Injury th, Day,Year)	28b. Tim	e of Inju	·	y at Work		8d. Describe	how injur	y occurred		
ion trendi leath. tor: /	Notural 5 Pending 1 Yes 2 No Investigation													
or Al after of Direc	The part of the pa								d Number	or Rural R	oute Number, City			
Di Hospital 24 hours ? Funeral tely filled		4 Homicide	(0,000.)						1		/->		a state of	- 1
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physiciau: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 1 Certifying F	Physician: To the beaminer: On the basis	s of examinati	vieage, death on and/or inve	occurre	n, in my opinion,	ne and pla , death oc	curred at t	the time, date	and plac	e, and due	to the cau	ise(s)
To To Cont	Med	29b Signature and title of certif	er /	stated			29c. License	e number			29d D	ate signed	(Month, E	Day, Year)
		10 a	tirlo 1	1/1/			O.C.N	M.E.			Febr	uary 21,	2007	
7	(	30 Name and address of perso	n who completed ca	use of death (	Item 23a)	•								
./\			Assistant Medic			Penn S	Street, Baltin	nore, M	D 2120	1				
	tate	31. Date filed (Month, Day, Year	07	Registrar's Sig	nature	e Res	9							
DHMH 17 Rev 1/2														

ALFRED L PARKS

			• •	partment of Health and Mental Hygiene 117 162
			1 _ State	artificate of Dooth
			Registrar  1. Decedent's Name (First, Middle, Last)	Reg. No.  2. Date of Death  3. Time of Death
	Physici		Alfred Louis Par	Month Day Year
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death
	LXamii	C1	Good Samaritan Hosatal	Baltimore NA
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthda)	
	Director		214-16-9258 <sup>1</sup> √2 M 2□F 84 Yrs.	Sept. 1,1922 Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits
	faryla fsho	ō	Maryland Baltimore	Middle River 1 ☐ Yes 2 ☒ No
	the 28a-	rect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Examinar must be notified at	by Funeral Director	112 Rodeo Circle	21220 United States
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
9	or ite	F.	1 Never Married 2 Married 1 Ves Give	1 Yes 2√ No Specify: Specify:
21215-0036	ural',	d b	3 Wildowed 4 Divorced Year or Dates: WWII	White
5	"nat	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given life)	pedent's Usual Occupation  we kind of work done during most of working  DONOT use retired)  Baltimore City
12	withi lene. than	m c	Elementary/Secondary (0-12) College (1-4or 5+)	ice Officer Law Enforcement
	filed I Hyg othar	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
<u>a</u>	uld be Aenta rked tic ev	To E	Raymond Parks	Anna Marie Ennis
Maryland	2 sho and 1 Is ma	·		illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and salth m 27		TILD: BODOFILEIO ET	Rodeo Circle Middle River, MD 21220
ore	ges 1 t of H If itel		1 Burial 2 Cremation 3 Bemoval from State	position (Name of ematory or other place)  Date 20c. Location - City or Town, State
Baltimore,	t. Partmen tent: njury		`4 □Donation 5 □Other (Specify) Gardens	s of Faith Cem. 3/2/2007 Baltimore, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic evant, the Medical Examinat must be notified at ODGe.			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.
			23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	7922 Wise Ave. Dundalk, Maryland 21222  anter the mode of dying, such as cardiac or respiratory arrest.  Approximate
	Dhamisian		Immediate Cause (Final	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	
	Examiner		Securation line and disease	Infarction
	p =	iner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	1 Pical
	and trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  C. Safto Mest (or as a consequence of):	inal bleed.
760,	be ex icien burial	cai E	530 10 (37 25 2 501004251100 51).	
687	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		d	
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
	death e atte	cia	in the past 12 months?  1 Vec 2 No. 4 Pregnant at time of death 5	3 □Ectopic pregnancy Month Day Year 5 □ Other (specify)
P.O.	at the by th tache	hys	9 ☐ Unknown	
	es tha	Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	
Records,	w require been si should l	ted	SEPTIC SHUCK	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown
ec	a law nas b e 2 st	nple	cardiac dysiny hmla	24a. Was an autopsy findings available prior to completion of cause of
H H	The cete		l t	performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
Vita	ician certifi rector	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of	Phye r this ral di	: To	27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)
on	nding th. : Afte s fune	tion	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	y Work? M 1 □ Yes 2 □ No
Division of Vital	Atter rr dea actor by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ó	s afte	Certification:	4 Homicide building, etc. (Specify)	Ony or rown, State)
	lospi t hour uner		29a. Certifier  (Check only  Check only  Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medicai	one) and manner stated.	29c. License number 29d. Date signed (Month, Day, Year)
	With To	~	29b. Signature and title of certifie	290. Date signed (Month, Day, Year)
	N		The Halland	10000 10000 1000 1000 1000 1000 1000 1
	511		30. Name and address of person who completed cause of death (Item 23a) (Type Kh US r 0/A) Tabassi. 11 5601	Loch Raven Blvd, Baltimore, MD 21239
	Sta	ite_	31. Date filed (Month, Day, Year)  32. Registrar's Signature	
	Registi		MAR 0 1 2007 Server St. April	

			For State Registrar	State of Ma	aryland		rtment tificate				ene	07	06220
			Decedent's Name (First, Middle, Las	t)						2. Date of Death		.,	3. Time of Death
	Physici		Laura F. Petti							Month February	Day 15,	2007	1841 M
	/Medio		4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or l	ocation of Death		4c. Count	y of Death	
			Atlantic General	Hospital				rlin			Worce	ster	
ĺ	Funeral Director		5. Social Security Number 6. Se 048-05-9003	7. Ag □M 2 AF	e (In yrs. Ias 94	t birthday) Yrs.	If Under 1 Months	Year Days	Hours Min.	8. Date of Birth (Month, Day, ) Oct. 4,	<sup>(ear)</sup> 1912	Cour	place (State or Foreign ntry) necticut
	D >		Usual Residence of Decedent  10a, State 10b, County		10c City	Town or Lo	calion					1	IOd. Inside City Limits
	arylan •how	ሯ					241011						1 ☐ Yes 2 X No
-	the M 28a-f	Director	Maryland Worceste	er	Ber1	ın	10f. Zip (	Codo		100	g. Citizen of	What Cour	2010/2
7	with t	급	1 Meadow Street					811			J.S.A.	Wilat Codi	шут
70	items 23a	eral	11, Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decede	ant of His	panic Origin? (Sp	ecify Yes or No-		ce - Americ	can Indian,
96	g a 5	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 📆 If Yes, Give Year or Dates:		11	Yes, specif	fy Cuban	Mexican, Puerto Specify:	Rican, etc.)	Special Special	ick, White, fy: Wh	etc. nite
47 LO3	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, any njury or other traumatic event, the Marital Hygiene.		15. Decedent's Ed			16a. Deced	ent's Usual	Occupat	ion	. 10	3b. Kind of E	Business/In	dustry
1	nin 72	Completed	(Specify only highest gra	de completed) College (1-4or t	5+1	(Give life. L	kind of work OO NOT use	r done du e retired)	iring most of work	ing			,
7 15	d with	E	12 Years	N/A	,,,	Home	naker				Her	own h	ome
7 7	other and	Bec	17. Father's Name (First, Middle, Last)						18. Mother's Name	e (First, Middle, Ma	aiden Sumai	me)	-
0 7	ally land	ToE	Horatio James Fre	nch					Laura K	ickes D	ickes		
7 0	s ma		19a. Informant's Name/Relationship (7	Гурө, Print)		19b. Mailin	g Address	(Street ar	nd Number or Rur	al Route Number,	City or Town	, State, Zip	Code)
1 =	and 2 alth a		Joan Whitney			389.	58 Mor	nroe		Selbeyvi	11e,	Delaw	are 19975
000 000	of He		20a. Method of Disposition	Domoval from State	20b. Plac	ce of Disponetery, cren	sition (Name	e of her place		Date 20	c. Location	- City or To	own, State
38	Page nent of int: H		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othe (Specify		Met	or Cr	ematio	on, I	Inc. 2/22	/2007 C	atons	ville	, MD
1	mait. Posts y nit.		21. Signatury of Fineral Service Lorent	see	7.5	22	Name and	Address	of Facility	1 77	-		
0	88558		1000 wo	iso			3415 <sup>e</sup> 1	ela:	ppel Func ir Road	eral Home Baltimor	e. MD	212	06
			3a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	d the death.	Do not ente	er the mode	of dying	, such as cardiac	or respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Book	dua	e As	Zi.					Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):	CVC						ave leavan
	Examiner			× /	Med.	rution		Din	oxa .	to xozity	,	4	La Karaya
~		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a conseque	nce of):		1					
0	te be executed ysicien and le burial-transit	Examiner	triat initiated events	c									
Ž,	e exe		resulting in death) Last	Due to (or as	a conseque	nce of):							
25	ate by	dical		d								-	
$\pm 1$	o ∯ de	Med	IF FEMALE:										
200	w requires that the death certification is signed by the attending should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pre					ate of delive onth	ery Day Year
CO	ne death the atter	200	1 ☐ Yes 2 12 No	4□Pregnant a 9□Unknown	t time of dea	th 5 ☐	Other (spe	ecify)			,,,,	Ontri	Day Tour
21	that the ed by th detache	Ph	9 Unknown			to or to also	4-4-5		- in Book	22a Did taha		المادة المسالمة	ha
2%	es tha igned l	à	Part II. Other significant conditions of	ontributing to death t	out not result	ing in the ur	iderlying ca	iuse give	In Part I.		2 □ No		he cause of death? pably 4 (9t/nknown
07	v requires v requires been sign should be	ed ed	1/2001	W C DEW D		1.00	3-25 11	1	124 1 1-11/00	10165	20140	3 [] F (0)	Sabiy 4 Gorkilowii
- 0	INISION OF VICE THE CONTROLL OF A RECORD OF A READING PHYSICISM. The law requiralism death.  Director: After this certificete hes been so in by the funeral director, page 2 should	흗	Corona	y sto te	ry d	1 Beas	R			24a. Was an autopsy	24b.	Were auto	ppsy findings available impletion of cause of
	The The page	ခြ	Hyzer	ten 55am						perform 1 ☐ Yes 2		death? 1 ☐ Yes	2□ No
	cian: cian: ertific	Be	25. Was case referred to medical examiner?					7		h Check only one			
3	hysia his c	မှ	1 Yes 2 No	Hospital: 1 Inpati		R/Outpatien			4   Nursing no	me 5 Residen			<i>(y)</i>
	ng P Mter t	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dale of Inju (Month, Da	iry 2 y Year) 2	8b. Time of Injury		Bc. Injury Work		28d. Describe hov	injury occu	rred	
•	STO Seath. Or: A	Certification:	2 ☐ Accident investigation				М		es 2□No				
•	or Att	E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At hom tc. <i>(Specify)</i>	e, larm, str	eet, factory,	office		28f. Location (Stre City or Town,	et and Num State)	ber or Rura	al Route Number,
(	ral D												
	DIVISION O'VICAL TO THE HOSPITED TO THE HOSPITED TO THE HOSPITED THE HOSPITED THE TO THE FUNETAL DIFFECTOR. After this certificate hes completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exan	ywiciam: To the best niner: On the basis of	of examinatio								
	the hin 2 the mplel	Med	one) 29b. Signature and title of certifier	and manner st	ated.		290	License	number	1 20	d. Date signe	ad /Month	Day Vaarl
	S 2 ₹ 5	-	290. Signature and title of certifier	1-19-			250.		10120	25	- /15	6-7	Day, rear
	4		7/17	9 June	non			0 9	1/50		0/13	1-+	
	W		30. Name and address of person who	/		23a) (Type,	Print)	1/	1	0	1. 1	10	
			31. Date filed (Month, Day, Year)	TOR ULUG:		ro /17	ealT	1-60	1 DAM	e Del	In p	1	
	Sta Regist	ate		2007 32. 139150	rar's Signatu	b A	1						
			MAR 0 1	LUUT AND	we h								
	DHMH 17 Rev 1/2	:001				200							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Keith M. Rollins 1710 Feb 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ ¥ 2 □ F Months Director 220-68-0447 Aug 11, 1952 Md Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No notified Director dgemere Md 28a-f 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 must be 2314 Ruth Avenue 23a 21219 Funeral filed within 72 hours after death Hygiene. 7 Is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify ۵ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Security Guard 12 and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernestine M. Foster Thessalonia Knight 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun 6 Sesame Court Reistertown, Md 21136 Melvin Knight Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Murial // 2 ☐ Cremation at TRemoval from State 4 □ Donetion 5 □ Other (Specify) 03/05/07 Baltimore, Md Holly Hill Memorial 21. Signature of Juney I Jervice Licen 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 23a. Part1. Enter the disease shock, or beart failure. e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Ca se (Final disease or condition resulting in death) DISEASE CORONARY ARTERY Physician Yrs /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DIABETES MEZLITUS burial-tran and Due to (or as a consequence of): Box 68760 attending physician pe Physician/Medical the use as IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes Division or Vital Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 2 DOA 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1/2 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident lospital or Attend hours after death: uneral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D22620 02/28/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 8 30 HOSPITAL DRIVE BACTMORE MD 21237 68 \$2. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

07-01560 Deborah Reese Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eborah Reese		State of Maryland 1- For State Registrar	/ Department o Certificate o		nd Mental		2 () eg No.	07 0622				
Physicia <u>Je</u> dical Examir		1. Decedent's Name (First, Middle, Last)  Debra L. Reese Debora		Date of Dea Month February	ith	3. Time of Death 1335 hrs						
		4a. Facility Name (if not institution, give street and number 3304 English Consul Avenue	)	4b. City, Town, o	r Location of De		4c. County of	Death				
Funeral Director			ge (In yrs. last birthday)	If Under 1 Ye		Airo	T <sub>F</sub>	9. Birthplace (State or Foreign				
,		214-04-9269 1 M 2 XF  Usual Residence of Decedent  10a State 110b County	39 Yrs				)/1967	Country) PA				
id how any ce,	r	10a. State 10b. County  MD Baltimore	10c. City, Town or Local					10d. Inside City Limits  1 Yes 2 XNo				
Maryland 28a-f show d at once,	Director	10e. Street and Number	L	10f. Zip Code		1	0g Citizen of What					
ith the 23a or notifie		3304 English Consul Avenu			1227			United States				
death w	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces 1 Yes 2	spanic Origin? ( n, Mexican, Pue	Specify Yes or No irto Rican, etc.)	14. Race - A White, e	American Indian, Black, etc.						
s after or ural", o	ρ	3 Widowed 4 Divorced If Yes, Give Year or Dates		Specify: V								
72 hour n "natu	mpleted	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or	of work done retired)	16b. Kind of Busin	ness/Industry							
215-0036 be filed within 72 ntal Hygiene. rked other than ent, the Medical	dmo	10 17. Father's Name (First, Middle, Last)		Food Se	ervice							
	Be Co	Melvin E. Reese, Jr.	me (First, Middle, Manager)  A. Rhoo	les								
MD 21 nd 2 should ulth and Mer m 27 is man aumatic ev	မ	19a Informant's Name/Relationship (Type, Print )  Melvin E Reese Tr Fat		nber, City or Town,	State, Zip Code)							
re, N s 1 and S f Health If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from St										
		4 Donation 5 Other Specify:	Oak Ridge	e Cemete	- 1	3/01/07		, Pennsylvania				
Balti permit Departn Importi		o Jeurg of Funeral Service Licensee	M01113 <sup>2. N</sup>	Name and Addres 309 Broad	s of Facility E. d Avenue	. Merrill e, Altoon	Smith Fi a, PA 166	neral Home				
Physician /Medical		23a. Part I. Enfer the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter t	he mode of dying	such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and				
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)  a. Mixed drug  Due to (or as a cons	(morphine, met	hadone, co	caine, al	prazolam) :	intoxicatio	n Death				
	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a cons										
ecuted and transit		d										
50, ate be ex aysician	Medical	IF FEMALE: 23c. If yes, outcor	,28a-f, perME,	g866, 4/1	7/07 TT		Lood Date of del					
ox 68760, eath certificate be ex attending physician for use as the burial		33b. Was decedent pregnant in the past 12 months?	2 Fe	tal death 3	Ectopic preg	nancy	23d. Date of del Month	Day Year				
Box te death the atte	Physic	1 Yes 2 No 9 V Unknown 9 Unknown	5 0	her (Specify)								
i, P.O.	ē	Part II. Other significant conditions contributing to deat	n but not resulting in the u	ınderlying cause (	given in Part I.	23e. Did to		e to the cause of death?  Probably 4  Unknown				
ords, v require s been si	Completed					24a. Was a	an 24b. Wer	re autopsy findings available r to completion of cause of				
tal Reco	Comi					perfor	med? deat					
Vital ysician: his certif	B	25. Was case referred to medical examiner?  Hospital. 1 Inpatie	ent 2 ER/Outpatient		of Death (Chec		Residence 6 🗸	Other Scane				
n of \ing Phy hing Phy After th	ا: 1	27. Manner of Death 28a. Date of Inju	ıry 28b. Time of I	njury 28c. Inju	ry at Work?		ow injury occurred	Julier, ocene				
Sior Attend r death. ector: by the i	ertification:	Natural 2 Accident Sinvestigation Investigation 3 Suicide 6 X Could not be 2/25/2007 Fnd 1:10 pm 1 Yes 2 X No unknown 2/25/2007 End 1:10 pm 2 Yes 2 X No unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural R										
Divi	ertifi	TOTAL TIP										
	Medical (	29a. Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner:On the basis of examiner				nd due to the cause	e(s) and manner as					
To with To con	Med	and manner stated.  29b. Signature and title of certifier		29c. Licens			29d. Date signed					
			us	O.C.	M.E.		February 26,	2007				
7		<ol> <li>Name and address of person who completed cause of cardinary and address of person who completed cause of cardinary and address of person who completed cause of cardinary and address of person who completed cause of cardinary and address of person who completed cause of cardinary and address of person who completed cause of cardinary and</li></ol>	' '	Penn Street,	Baltimore, N	MD 21201						
Sta Registr	tate 31. Date filed (Month, Day, Year) 32. Revistrar's Signature											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Travis Lashawne Robinson

2007 06223

	1- For State Registrar		tificate of L	Death		Reg. No.	The state of the s	
Physician/ Medical Examine	Travis Lasha	wne Robinson			2. Date of De Month January	Day Year 28, 2007	3. Time of Death 0440 hrs	
v T	4a. Facility Name (if not institution, Prince Georges Hospita	,		. City, Town, or Location Cheverly	of Death	4c. County of I Prince Ge		
Funeral Director		Sex 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year If Und Months Days Hour		3/1977	9. Birthplace (State or oreign County)	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-f show any r other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Princ.  10e. Street and Number  3820 Cedar Dr.  11. Marital Status  1 Never Married 2 Marria  3 Widowed 4 Divor  15. Decedent's Education (Specif Elementary/Secondary (0-12)  1 2th  17. Father's Name (First, Middle, L. Robert Robins	ive  10c. City, Suis  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ced If Yes, Give Year or Dates: y only highest grade completed) College (1-4 or 5+) ast) Con Citype, Print)	Town or Location tland  S. 13. Was I If Yes,  1 Y.  16a Decedent's during most  Crane  19b. Mailing A.  3820	Of. Zip Code  20746  Decedent of Hispanic On, specify Cuban, Mexicar es 2 X No specify  Usual Occupation (Give of working life DO NOT  Openator  18. Mothe Ann.  ddress (Street and Nur  Cedar Dr.	igin? ( Specify Yes or Nn, Puerto Rican, etc.) kind of work done use retired) r's Name (First, Middle, i.e. Ree Mo	10g. Citizen of What  USA  0- 14. Race - A White, e Specify: £  16b. Kind of Busin Perini/ Maiden Surname)  nnoe.	10d. Inside City Limits 1	
Baltimore, M permit. Pages I and 2 Department of Health, Important: If item 2 injury or other traum	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec  21 Signature of Furreral Service Li	3 Removal from State Resify:	rematory or other	tion Cem.	V			
Physician /Medical xaminer	23d. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. each line. a. Gunshot Wound of Abdo Due to (or as a consequence of)	Do not enter the i	mode of dying, such as o	cardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death	
couted and transit		Due to (or as a consequence of)  C.  Due to (or as a consequence of)  d.	):					
50, te be exec systeian ar systeian ar burial - t	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of pregna	-					
D. Box 68760, the death certificate be executed by the attending physician another for use as the burial - translated for	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	1 Live birth 4 Pregnant at time of dea	2 Fetal	death 3 Ectopio	c pregnancy	23d. Date of del Month	very Day Year	
Records, P.C. The law requires that ficate has been signed regge 2 should be dea Completed by		s contributing to death but not res	sulting in the unde		1 Ye  24a Was auto perfo	an 24b Were prior deat		
Vital   hysician: this certif	examiner?	Hospital: 1 Inpatient 2 V E	ER/Outpatient 3	26 Place of Death		Residence 6 0	ther:	
ion of V trending Phy death. tror: After th / the funeral of	1 V Yes 2 No  27. Manner of Death  Natural 5 Pending  Accident Investig	28a. Date of Injury (Month, Day, Year) Jan 28, 2007	28b. Time of Injur 0259 hrs		? 28d. Describe	how injury occurred	rner:	
Division of opposite of the control	3 Suicide 6 Could n 4 Homicide determin	ot be ned (Specify) Tavern			or Town, S 12617 Laure	State) el Bowie Rd., Laure		
To the Hospital within 24 hours To the Funeral completely filled	(Check only   Certifying Phys	ician: To the best of my knowledge ner: On the basis of examination and and manner stated	e, death occurred d/or investigation,	at the time, date and pla in my opinion, death occ	ice, and due to the caus curred at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)	
Me services	29%. Signature and title of certifier	Mu)		29c. License number O.C.M.E.		29d. Date signed (		
3	30. Name and address of person what Laron Locke MD. Ass			reet, Baltimore, MI	D 21201		<b>*</b>	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	е					
Registrar	MAR 0 1 200		ORIGINAL					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 donth 20 Physician Richardson 2007 Brenda J. 7:45a.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Mariner Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Min Hours 1 🗆 M Oountry) 212-56-8247 1950 Director 4 26 56 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d Inside City Limits ns 23a or 28a-f show must be notified at Baltimore Towson 1 ☐ Yes 2 X No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 1B 21286 Court 6 Ecoway USA Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2014 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: Black 2 3 Widowed 4 Divorced Completed er than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic evi Delores Daniels ٧. Roosevelt Shipman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nd 6 Ecoway Ct. Apt. 1B Towson, MD 21286 19a. Informant's Name/Relationship (Type. Print) Thomas P. Richardson-husband 6 Ecoway Ct. Apt. Health : 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If Its any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/07 Baltimore Co. MD Arbutus Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee B 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and A The law requires that the death certificate be executed physician a P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate ha 2□ No

25. Was case referred to medical 1 Yes 2 No

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

29b. Signature

1 🗷 Natural

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

St # 308

29d. Date signed (Month, Day, Year)

1 ☐ Yes

To Be

Medical Certification:

funeral dir

after death.

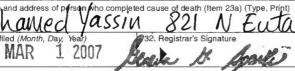
Director: /

within 24 hours at To the Funeral Completely filled i

State Registrar

2007

nd title of certifier



DHMH 17 Rev 1/2001

Hospital or Attending Physician:

To the

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 28, 2007 **Physician** Goldv K. Ritchie 11:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Morningside House of Ellicott City Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Days Hours Director 213-26-7189 Virginia 1915 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 → No Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 238 9522 Powderhorn Lane USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 2 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ō. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify White δ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry e kind of work done during most of working

DO NOT use retired) then. Elementary/Secondary (0-12) College (1-4or 5+) 9 Assembly Worker Mfg. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked oth jury or other treumatic even Be Mattie Whitt Russell S. Killen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Armagh Drive, Baltimore, Maryland 21212 Harriet A. Kerr / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. Mar 5, 2007 Elkridge, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. by Physician/Medical be detached for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown nis certificate has been si I director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ۵ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital within 24 hours of Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lane ( 5005 Signa SUZan Bdo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Mnn Khoades 1318 Nrc 2 07 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimate Manyland Medical Crate Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 177-30-7586 1 XM 2 ☐ F 68 Director APRIL 29,1938 PENNA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ar than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director PA. YORK YORK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 520 S. DUKE ST 17403 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or have any injury or other transmant. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) -12--0-HOMEMAKER PERSONAL RESIDENCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HUNTER 2 FRANCES HOLMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DONALD J. RHOADES SR (HUSBAND) 520 S. DUKE ST. YORK, PENNA 17403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State

**Physician** /Medical Examiner

and

the attending physician thed for use as the buna

page 2 should be detached

signed by

After this certificate has been

within 24 hours after death To the Funeral Director:

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the bunial-tran

IF FEMALE

23b. Was decedent pregnant

I□Yes 2□No

9 Unknown

1. Natural

2 Accident

3 ☐ Suicide

4 Homicide

in the past 12 months?

21. Signature of Fu

Immediate Cause (Final disease of Indition

resulting in death)

1 Burial 2 □ Cremation

☐Other (Specify)

neral Service do

Je howie crento Vagaular Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

orcham

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

LEBANON CEMETERY

12 23a. Part1. In or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

> 23d. Date of delivery Month

YORK, PENNA.

Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□Unknown

24a. Was an perform

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

Year

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury 5 Pending investigation (Month, Day Year) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

determined

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Boltimore

2-28-2007

822 E. MARKET ST. YORK, PENNA. 17403

HIBNER And Address of Facility JOHN H. DANNER FUNERAL HOME, INC

MY FICION 38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

0060201

29d. Date signed (Month, Day, Year)

MINGERIF 31. Date filed (Month, Day, Year)

MAR 0 1

29b. Signature and title of certifier

land

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SHAH SARO 0200AM FEBRUAR Y 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore Under 1 Year | If Under 24 Hrs. | Min. Johns Hopkins N/A If Under 1 8. Date of Birth (Month, Day, Year) JAN 24, 19 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 TyF 57 219-13-0314 Director 1950 Tanzania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3907 Link Ave 21236 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ 3 Widowed 4 Divorced Asian Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemist MSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rainikant Shah Taraben Shah ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Link Ave Baltimore, MD 21236 Kirit Shah/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 3/1/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring MacNabb Funeral Home, P.A. 301 Frederick Rd Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRIAL HYPOTENSION **Physician** FIBRILLATION HOURI /Medical Due to (or as a consequence of) Examiner RHEUMATIC HEAR YEAR 1 Exqueritually list our different if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the aftending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No autopsy perform 1∐ Yes 2.21No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hosping Within 24 hours after No the Funeral D Trifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Threet Baltim & MD 21287 - 910 awat ish 600

Registrar

State

31. Date filed (Month, Day, Year)

MAR 0

2007

732. Registrar's Signature

		•	For State Registrar	State	of Maryland		artment <i>rtificate</i>			and iv	ieniai m	Reg. No.	07	06228
			1. Decedent's Name (First, Mid	Idle, Last)	_						2. Date of D		Year	3. Time of Death
	Physicia /Medic		SHIRL	EY	Sm1	TH.					Fe 5	24	2007	12:28 PM
	Examin	er	4a. Fecility Name (If not institut	. •			4b. City, T				4 -		ounty of Death	
			BALTIMORE	~ ASHW	YOTON M	€0 er					RMIE	Anr	re Aru	rdel
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔏	7. Age (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Mar.	irth Jay Year) 10 102	9. Birthp	place (State or Foreign htry)
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	ams arms	ıner	11. Marital Status	12. Was D	ecedent Ever in U.S Forces?	S. 13.	Was Decede	ent of His fy Cubar	spanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	10- 14	. Race - Americ Black, White,	
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/lar	should be filed withir nd Mental Hygiene. I marked other than umatic event, the M	To B	Colverde Test	er					Jean	ette	Dove			
Maryland	and ls mu		19a. Informant's Name/Relatio	nship (Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Run	al Route Num	ber, City or 7	Го <b>w</b> п, State, Zip	Code)
	and lealth m 27 her tr		Mr. Everett S	Smith/Husl		7 lace of Dispo	107 A	vesb	ury 1	Lane	Glen	Burnie	. MD 21	061
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow amy injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.		20a. Method of Disposition 1 XBurial 2 ☐ Crematio		om State	emetery, crei	matory or oth	her place	1	Feb	28,		tion - City or To	
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Bal	permit. Dep. rtr Importe any inji		21. Signature of Funeral Service	1 Licensee	1 4000								, MD 21	e, P.A.
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DHMH 17 Rev 1/2001

	-	For State Registrar	State of Marylar		artment of F <i>rtificate of</i>			giene Reg. No	07	06229
		Decedent's Name (First, Middle, Last	t)				2. Date of Dea Month	Liver Helf	Year	3. Time of Death
Physicia /Medic		Sharon	Kay	Stı	ubbins		Februar	· ·		7:15 A <sup>M</sup>
Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1		y of Death	
over what is		720 Old Stage Ro			Glen Bu				Arund	
Funeral Director		442-44-0121		last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan . 1	, 1945	9. Birthp Cour	place (State or Foreign htry) MO
and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
faryla sho	ō	MD Anne Aru	nde1 G1	en Burn	ıi e					1 ☐ Yes 2 ▼No
the N	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
with Sa or t be r	₫	720 Old Stage Roa	d		2106	1		U.S.A.		
ns 2%	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.		fispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		ce - Americ	
регтіі, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		f Yes, specify Cub 1 ☐ Yes 2 No		o Hican, etc.)		ack, White, fy: Whi	
72 ho	ted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	dent's Usual Occup	ation during most of wor	kina	16b. Kind of E	Business/Inc	dustry
thin 7	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	1		during most of wor d)	,9			
ed wi ygien rer th t, the	ပ္ပ		2	Sr. I	ab Techn		- (F:			acturing
be fill ad oth even	To Be Completed	17. Father's Name (First, Middle, Last) Charles Evans				Unkno	ne <i>(First, Middl</i> e,	Maiden Surna	me)	
narke	유	19a. Informant's Name/Relationship (	Timo Print)	10h Mailir	na Address (Street	and Number or Ru		ar City or Town	State Zin	(Codo)
d 2 st th and 7 is n traun		Mr. William E. St				ge Road (				*
1 and Health em 27 ither tr		20a. Method of Disposition			sition (Name of matory or other pla		Date 27	20c. Location		
Pages nent of I		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		natory or other pla .ke Crema	1	007	Steven	evill	e MD
artme ortan injur	-	21. Signature of Funeral Service Licer		-	2. Name and Addre		ingleton			
permit. Depart Import any inj		Mark R V	/ /			Avenue SV	_			•
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final	Chamic	Ohs	truction	e Pi Day	inacy	Deina	40	Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consec		(100.0110	· · · · ·		ar case	7.50	
Examiner		Sequentially list conditions.	b				0			
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec							
ficate be executed physician and sthe burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):						
ficate physis the	edical		-d							
Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 [	Ectopic pregnand Other (specify)	у			ate of delive	ery Day Year
hat th d by detacl		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cor	ntribute to t	he cause of death?
signe	l by	-	-	ŭ	, 0		120	res 2 No	3 ☐ Prob	pably 4 ☐ Unknown
requestion requestions	etec	Hyperten Hyperlipi	1				24a. Was	00 24h	Mara auto	anay findings available
ne law has l	Completed	Hyperlopi	demia				autor	osy rmed2	death?	ppsy findings available mpletion of cause of
n: Th jicate r, pag		OF M						rmed? 2 No	1 ☐ Yes	2 □ No
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 5	ÉEB/Outration	t all post Oti	nor:	ath (Check only o			
Phy or this oral di	.: To	27. Manner of Death	28a. Date of Injury	28b. Time o			fome 5 ☐ Resid			у)
rth. :: Afte	tio	1 Avatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2∐No				
Atter r deal ector by the	Certification:	3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At h	nome, farm, str	reet, factory, office		28f. Location (S City or Tox	Street and Num	ber or Rura	al Route Number,
al or s afte	Sert	4 El Torridae	ballang, etc. (opec	(1 <b>y</b> )			City of 101	vii, State)		
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical (		nysician: To the best of my kn miner: On the basis of examin and manner stated.							
thin 2 the	Med	29b. Signature and title of certifier	and marmer stated.		29c. Licen:	se number		29d. Date sign	ed (Month.	Dav. Year)
Z × Z 8		M D	11/-			040413			1271	
/		30. Name and address of person who	completed cause of death (Ita	m 23a) (Tyne					, ,,	•
5			Summers, 1	20a) (19pe,	7010 R.	t- a	this	61em B	umi	ms 21061
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	M	, control	7	2,220		, , , , , , , , , , , , , , , , , , , ,
Registi	ar	MAR 0 1	Signature 32. Registrar's Sign	B. A.	DARKE!					
HMH 17 Rev 1/2	001		-	8						

State
Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

or Vital

Division

two Gambrits

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tava Muscovich
31. Date filed (Month, Day, Year)

			1 - For State Registrar	State	of Mar	yland / De	partment of Fertificate of	lealth and			06231
			Decedent's Name (First, Midd	tle, Last)				D Gairr	2. Date of Dear		3. Time of Death
Н	Physicia		Elena Seskuna	S					Februar	y 23, 200	7 6:11 A M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town, o	r Location of Dea	th	4c. County of De	ath
			Summit Park H	eath & Re	hab		Catonsv			Baltimo	ore
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕏 F		(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) C	rthplace (State or Foreign ountry)
	Director		213-30-7814 Usual Residence of Decedent	X		32 Yrs.			March 1	8, 1924 L	ithuania
	/land		10a. State 10b. Count	у	1	IOc. City, Town or	Location				10d. Inside City Limits
	Man Perfek	tor	Maryland Balt	imore		Bal	timore				1 ☐ Yes 2 No
	th the	Directo	10e. Street and Number				10f. Zip Code		1	Og. Citizen of What C	ountry?
	23a unit		108 Edgewood	Road			212	36		USA	
	ar deg	Funerai	11. Marital Status	12. Was De Armed F	orces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (S an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Ma 3 🌠 Widowed 4 ☐ Divorce	If Yes G			1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
8	2 hou	ed		nt's Education		16a. Dec	edent's Usual Occup	ation		16b. Kind of Busines	
215	hin 7;	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	(Gi	re kind of work done . DO NOT use retired	during most of wo d)	orking		
7	giene giene er th	Som	8	0	(1 15.57)		emaker			Own Hor	ne
nd	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or tteme 23e or 28e-f ehow event, it is Medical Examinar must be myllled at	Be	17. Father's Name (First, Middle						me (First, Middle, I	Maiden Sumame)	
<del>Z</del>	ould Men narke	P	Antanas Frice			11		UNK			
Maryland 21215-0036	d 2 sh th and 7 ie n traun		19a. Informant's Name/Relation Vito Seskunas							; City or Town, State, yland 2128	
	1 and Healt tem 2		20a. Method of Disposition	/ Son		20b. Place of Dis	position (Name of		-	y Latiu 2120 20c. Location - City o	
<u></u>	ages ant of nt: if if		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State		iematory or other plac Park Cemet		6/2007	Baltimore,	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, it a Medical Examinat mutt be mutilied at once.		21 Signatur of Funeral Service				22. Name and Addre			uneral Hon	
ä	Depariming Department of the construction of t		Suhand	Ch	-Du	J	4107 Wilke				land 21229
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause on	caused the	ne death. Do not e					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Der	menti	.a					Onset and Death  3 years
	/Medical Examiner		resulting in death)	Due to	o (or as a	consequence of):					1
В	LAGIIIIICI	<u>_</u>	Sequentially list conditions,	_ U	rebra	1 Ather	roscierosi	S			4 years
Г	nslt	nine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< '		nension					20 years
<u>,</u>	execunand nand ial-tra	Examiner	that initiated events resulting in death) Last			consequence of):					20 years
8760,	cate be executed physicien and the burial-transit	dicai		d							1
9	ntifica ng ph as th	Jedi	IF FEMALE:								
Box	ith cer tendir or use	an/N	23b. Was decedent pregnant	23c. If yes, or 1 ☐ Live			☐Ectopic pregnancy			23d. Date of de	,
о П	The law requires thet the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□ Unk		ne of death 5	Other (specify)			Month	Day Year
P.O.	thet the	Phy	Part II. Other significent condit	ions contributing to	death but	not resulting in the	underlying cause giv	en in Part I	23e. Did toh	nacco use contribute t	o the cause of death?
ds,	signe of be	d by	Bipolar Dis				ondonying oddoo giv	orran are i.	1 □ Ye	1/	robably 4 Unknown
S	w req	Completed							24a. Was a	24h Were 3	utoney findings available
Re	he lav e has age 2	duc							autops	prior to death?	
ta	ucian: Th certificete rector, pag	0	25. Was case referred to medic	al				26. Place of De	ath (Check only on	No 1 Ye	s 2MNo
>	Physician: r this certificanal director,	To B	examiner?	Hospital: 1	] Inpatient	2 ER/Outpat	ent 3 DOA Oth	er \		nce 6 □Other (Spe	ecify)
0	ding Pl	 0	27 Mann o Death Natural 5 ☐ Pend	28a. Date (Mo	of Injury nth, Day	(ear) 28b. Time	Wor	at k?	28d. Describe ho	w injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident inves	tigation	/ 1 - /	411	100	Yes 2 □No	Last v. V. va.		
Division of Vital Records,	or Al after of Direct in by	Certification:		mined 289. Plac	ding, etc.	(Specify)	street, factory, office		City or Town	reet and Number or P r, State)	ural Route Number,
_	spitei ours nerei filled		29a. Certifier 1 Certify	ing Physician: To th	e best of	mv knowledge, de	ath occurred at the tin	ne, date and place	e and due to the ca	use(s) and manner a	s stated
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	edicai	(Check only 2 Medica	I Examiner: On the	basis of e nner state	xamination and/or	investigation, in my o	pinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	or la da			29c. Licens	e number	20	9d. Date signed (Mon	th, Dey, Year)
)			A CONTRACTOR				V	417	10 1	ebhoar	12312 2007
	2	93	30. Name and diress of person	who completed cau	se of dea	th (Item 22a) (Typ	Print)	- 1 1-1	200		12. 12
	V		LEONEU	SHR	1	Signatura =	7707	of you	was L	and p	c 40 43
30	Sta Registr		31. Date filed (Month, Day, Yea	1 2007	Said .	s Signature	( Jane	)			
	-		MAR 0	T TARLI	-		7				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #21,22,perFH, G865, 3/1/2007 TT Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) o Year Physician enneth 1000 am 02 16 /Medical 4a. Facility Name (If not institution, give street and number, County of Death 4b City, Town, or Location of Death Examiner alt cltimare Mare ) eccurs If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, Birthplace (State or Foreign Country) Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Days 218-64-2212 Months 1 M 2 □ F Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at 1 XYes 2 No Director 10g. Otizen of What Country? 10e. Ştreet and Number Pages 1 and 2 should be filed within 72 hours after death with ō -IRMOUNT Funeral or Items 23a 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION THGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NETTIE ALTIHORE Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial /2 ☐ Cremation 3 ☐ Removal from State NSDOWNE 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March E/H Fast ignatu Glavos IS Warner 23e art1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Intrindiate Cause (Final dylease or condition sulting in death)

a. Due to (or see accessions) Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 9 Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, FEB

2

Name and address operson who completed cause of death (Item 23a) (Type, Print)

2007

2000 ( 32 Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per int g883 9-10-08 vt
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		y rair a	Cer	tificate of l	Death	woman n	Reg. No	2007	0.5233
	LEL	ч	1. Decedent's Name (First, Middle, L	ast)		-			2. Date of D Month		Van	3. Time of Death
	Physici /Medic		Akira Sano						Februa	Da rv 2	Year 24, 2007	5:35P M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deat		_	. County of Dea	
7	_ Xuiiii		7010 Kepner Cour	t			Lanham			P	rince G	aarga!g
	Funeral		*		(In yrs. las	st birthday)	If Under 1 Year		8. Date of Bi	irth	9 Bir	thplace (State or Foreign
	Director		554-48-7638	1፟∭M 2□F	70	Yrs.	Months Days	Hours Min.	(Month, D		) C	vada
			Usual Residence of Decedent		70	l l			DCC. I	. ۱	JJU   NE	vaua
	yland iow		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mar-f sh	ţ	D.C		Wash	ingto	n.					1∭Yes 2 No
	the 728a	rec	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	Sa ou	Funeral Director	490 M Street, S	TJ #TJ310			20024			Unii	ted Star	tos
	ns 2; mus	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V		ispanic Origin? (S	Specify Yes or N		14. Race - Ame	
	fter d iner	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ 1	lo	li li	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puèr	to Rican, etc.)		Black, Whit	te, etc.
98	rs af		3 ☐ Widowed 4 █ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	☐Yes 2☐No	Specify:			Specify:	sian
Ş	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's	Education	- 1		ent's Usual Occup			16b. K	and of Business	
21215-0036	n "n Aedi	plet	(Specify only highest g			(Give I life. D	kind of work done of NOT use retired	during most of wo i)	rking	De	epartmen	nt of
72	with iene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5 4	"  D	eputy	Chief of	f Civil	Rights	1	ransport	
0	Hyg Hyg ent,	C	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle			
an	d be ental ced c	o Be	Densaku Sano					Chivo	ko <del>Tsun</del>	-4-	Volendo	
≥	houl d Me mark mati	ဥ	19a. Informant's Name/Relationship	(Type Print)		19b. Mailin	g Address (Street					Zin Code)
Maryland	d2s than 7 is trau		Holly J. Cody/Da									
	1 an Heal em 2 ther		20a. Method of Disposition	agnrer	20h Plac	ce of Dienos	Kepner Co				and 207 ocation - City or	
ğ	ages nt of irite		1 ☐ Burial 2 ⚠ Cremation 3		Mont	netery, cren gomer	natorý or other plac Y		ch 1,	20012	oodiion ony or	Town, Oldio
∄	t. Pa tmer tant ijury		4 □ Donation 5 □ Other (Spec		Crem	atori	um Tnc	1.200	7	Bet	thesda,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signal in filmeral Service Lie	ensee	1100	Be	thesda-Cl	nevy Cha	se, Inc.	75	7 Wisco	ineral Home/ onsin Avenue
_	<u> </u>		1 Show	evuy.		oodge	tnesda, r	Maryland	20814-	-3501	L	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. e.	Do not ente	er the mode of dyin	ig, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a. Lung	Cance	r						Onset and Death
1	/Medical		resulting in death)	Due to (or as			-					
Ŀ	Examiner			b								
۳		ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	nce of):						
/	rtificate be executed og physician and as the burial-transit	Examiner	that initiated events	C								
ó	exe an ar rial-t		resulting in death) Last	Due to (or as a	conseque	nce of):						
68760,	te be ysicia ie bu	Medical		d								
89	tifica g ph as th	edi										
Вох		2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			E 17.				23d. Date of de	livery
_	res that the death ce igned by the attendii be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
О О	the sy the ache	hys	9 ☐ Unknown	9LlUnknown								
	that ned b		Part II. Other significant conditions	contributing to death bu	ıt not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
Records,	law requires that the as been signed by th 2 should be detache	d by							1贤	Yes 2	□No 3□P	robably 4 Dunknown
2	w require been sign	ete							24a. Was	e an	24h Wara a	utopsy findings available
æ	g ii	Completed							auto	psy	prior to	completion of cause of
	i <b>clan:</b> Th certificate ector, pag								1□ Yes	ormed? 2 <b>X M</b> Vo	1 ☐ Yes	2 □ No
E.	iclar Sertif ecto	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only			Daughter's
o.	Physiclan: r this certific ral director,	ပ္	1 Yes 2 No	1 ☐ Inpatie			3 DOA Oth	4 🗆 Nursing r				ecify) Residence
Ē	ng ffe	iuo	1X Natural 5 ☐ Pending	(Month, Day		8b. Time of Injury	28c. Injur Worl		28d. Describe	now inju	ry occurred	
Sic	Attending r death. ector: Afte oy the fune	cati	2 Accident investigat 3 Suicide 6 Could not	ha				Yes 2 □ No		100		
Division or Vital	or At fter d lirec n by	Certification:	4 Homicide determine	d 28e. Place of inju- building, etc	ry - At nom :. (Specify)	e, tarm, stre	eet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or R e)	ural Route Number,
	urs a			7					1			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Ex	Physician: To the best on the basis of the b	examinatio	edge, death on and/or inv	occurred at the tire tire tire tire occurred at the	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause(s e, date an	<ul> <li>and manner as d place, and due</li> </ul>	s stated. e to the cause(s)
	the hin 2 the npled	Med	one)	and manner sta	tėd.		29c. License	e number		204 5	to oigned (14	th Day Vo-1
	Vit COC	=	29b, Signature and title of certifier								ite signed (Moni	
			Muth	3/			D527	6/		Feb	ruary 2	7, 2007
	20		30. Name and address of person with									
	đ		Harminder Sethi				reet, N.V	V., #218	S, Washi	Ingto	on, D.C.	20010-2975
	Sta		31. Date filed (Month, -Day, Year)	32. Registra	ır's Signatuı		·					
į.	Regist	ar	MAR 0 1	2007 /	as l	1 6	action .					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State	of Mar			artment of latificate of				iene g. No.	2007	06234
	Dhuaiai		1. Decedent's Name	(First, Middle,	Last)					-		Date of Deat Month		Year	3. Time of Death
	Physicia /Medic		Dorothy	Gail S	hifflett	t					F	ebruary			12:20 AM
	Examin		4a. Facility Name (If						4b. City, Town,	or Location	of Death		4c.	County of Dea	th
			Montgomery V						Montgo					Montgo	
	Funeral		5. Social Security Nu 579-42-66		i. Sex 1 ☐ M 2 🖾 F		In yrs. last birt 73	naay) Yrs.	If Under 1 Year Months Days		Min.	. Date of Birth (Month, Day,	Year)	Co	thplace (State or Foreign
	Director	}	Usual Residence of				/3				100	ovember.	3U,	1933	<u> Michigan</u>
	land ow		10a. State	10b. County		14	0c. City, Town	or Lo	cation						10d. Inside City Limits
	Man	후	Maryland	Mont	gomery			1	Montgome	ry Vil	llage				1 X Yes 2 □ No
	h the	irec	10e. Street and Num	ber		•			10f. Zip Code			1	0g. Citi:	zen of What Co	ountry?
	th wit	a	19301 Wat	kins Mi	11 Road				20	886			Ut	nited S	tates
215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or Items 23a or 28a-f ehow aumatic event, it a Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		12. Was De Armed I d 1 Tes If Yes, C Year or	Forces? s 2⊠No Give	er in U.S.	1	Was Decedent of f Yes, specify Cul I ☐ Yes 2区 No	oan, Mexica	n, Puerto Rio	fy Yes or No- can, etc.)		14. Race - Ame Black, Whit Specify: W	
Ş	2 ho	ted	(5	15. Decedent's	Education		16a.	Deced	lent's Usual Occu	pation	et of working		16b. Kir	nd of Business	/Industry
2	hin 7	Completed	Elementary/Secon	<del>, , , , , , , , , , , , , , , , , , , </del>	grade completed College	(1-4or 5+)		life.	DO NOT use retire	ed)	st of working				
7	or the	NO.			2				Secreta						overnment
2	be file tat Hy d oth	Be	17. Father's Name (	First, Middle, La	ast)							First, Middle, M	<i>laiden</i>	Sumame)	
⋛	Men Men Marke Marke	٩	(Unknown		_						salie				
Maryland	12 sh n and r is m		19a. Informant's Na			. 1			g Address (Stree				•		
a)	1 and Health		Susan L.		r / Daug	-			Wasche sition (Name of	1				cation - City or	
چ	ages nt of i		1 ☐ Burial 2 🖯	Cremation 3	Removal from	m State	cemeter	y, crer	natory or other pla		eb. 25	5,			
altimore,	it. Partiment		4 ☐ Donation  21. Signat@reyof Fur				Montgo	mer	y Cremat	ess of Facili	vRober		seth	hrev Fu	Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evens.		> Sh 1	h h	-		01473	Re	ockville ockville	, Inc.	300 yland	West 1 20850-	Mont 2805	gomery	neral Home/ Avenue,
			23a. Part 1. Enter the shock, or hear	e disease, or c t failure. List o	omplications that nly one cause or	t caused the each line.	e death. Do n	ot ent	er the mode of dy	ing, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
Z	Physician		Immediate Cause (i		_aSe	psis									Oriset and Death
	/Medical Examiner		resulting in death)	1	Due to	o (or as a c	onsequence o	of):							
		<u></u>	Sequentially list con	nditions,			Tract		fection						
Τ	led Isit	nine	cause. Enter Under Cause (Disease or i	njury	5001	c (0, as a c	oneoquenca c	,,,							
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) L		c	o (or as a c	consequence	of):							
8760,	cate be executed physicien and the burial-transit	dical			d.										
89		w I								1,700			-		
P.O. Box	thet the death certifi led by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12   1 □ Yes 2 ☑ 9 □ Unknown	months?		e birth 2 ( gnant at tim	Fetal death		Ectopic pregnand Other (specify)				2	23d. Date of de Month	livery Day Year
	The law requires thet the ste has been signed by th bage 2 should be detache	by PI	Part II. Other signifi	cant condition	s contributing to	death but r	not resulting in	the u	nderlying cause g	iven in Part	l.	23e. Did tob	acco u	se contribute to	the cause of death?
2	quires in signe											1 □ Y€	s 218	ŽNo 3∏Pi	robably 4 Unknown
ပ္ပ	aw requir s been si 2 should l	Completed										24a. Was a		24b. Were at	utopsy findings available
ž	The law	mo										autops perform	ned?	death?	completion of cause of 2 □ No
ā	iclan: Th certificete ector, pag	Bec	25. Was case referr	ed to medical	Tu					26. Ptac	e of Death (0	Check only on			
<b>&gt;</b>	ysiclan: nis certific director,	ToE	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 [	□Inpatient	2 ER/Out	tpatier	t 3 DOA	ther: 4 🙀 Ni	ursing Home	5 ☐ Reside	ence 6	3 □Other (Spe	city)
o uo	Attending Physiclan: r death. ector: After this certifice by the funeral director, t		27. Manner of Death  1   Natural  2   Accident	n 5 ☐ Pending investiga		te of Injury onth, Day Y	'ear) 28b. T	ime of njury	W	uryat ork? ∐Yes 2 □		d. Describe ho	w injury	y occurred	
Division of Vital Records,	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide	6 ☐ Could no determin	ed 286. Pla	ce of Injury Iding, etc. (		rm, str	eet, factory, office	)	28	f. Location (St. City or Town			ural Route Number,
_	Hospital or Ai 24 hours efter of Funeral Directions of the control		29a. Certifier	1 <mark>∰ Certifying</mark>	Physician: To t	he best of r	ny knowledge	, deat	occurred at the vestigation, in my	time, date ar	nd place, and	d due to the ca	ause(s)	and manner as	s stated.
	n 24 h	edicai	(Check only one)	2 Medical E	xaminer: On the and ma	basis of example anner state	camination and d.	d/or in	vestigation, in my	opinion, dea	ath occurred	at the time, da	ate and	place, and due	to the cause(s)
	To the twithin 2.	ž	29b. Signature and	title of certifier					29c. Licer	ise number		2	9d. Date	e signed (Mani	h, Day, Year)
!					Mus	~	X		H00	51280		F	ebru	ary 23	, 2007
	2		30. Name and addre	· ·							11 0 0 -				1 1 2005
-	· ·		Anushirav			-	4	1	Center D	rive,	#201,	Rockv:	ille	, Mary	land 20850
	Sta Registi		31. Date filed (Mont	MAR 0 1	2007	Angistrar's	Signature	A	meter						
-			-			THE RESIDENCE OF THE PERSON NAMED IN		A							

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryl		artment of I		Mental Hy	/giene Reg. No. 007	06235
	Dhysisi	-	1. Decedent's Name (First, Middle, Last					2. Date of D	eath Day Year	3. Time of Death
	Physici /Medic			cald B. Selz	er			Februa	ary 19, 2007	2:26 A M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Dea		4c. County of Dea	
	Comment		Holy Cross Hospit 5. Social Security Number 6. Se	:al x	yrs. last birthday	Silve If Under 1 Year	r Spring		Montgon	nery thplace (State or Foreign
0	Funeral Director			M 2□F 6.		Months Days	Hours Min			ifornia
da	pu ,	1	Usual Residence of Decedent	100	City, Town or L	acation .		12108 • 1	0, 17-15   001	
	faryla shov	ō	10a. State 10b. County  Maryland Montgome		City, Town of E	Potomac				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N 28a-f	rect	10e. Street and Number	ТУ		10f. Zip Code			10g. Citizen of What Co	
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	10407 Great Arb	or Drive			)854		United Sta	tes
	deatl	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of I	Hispanic Origin? (	(Specify Yes or No		rican Indian,
36	or it	by Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🙀 No		,	Specify:	
Ö	hours itural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occu	nation		16b. Kind of Business	White
15	nin 72 n "na Medic	plet	(Specify only highest grad		(Give	kind of work done DO NOT use retire	during most of w	orking	Too. King of Basiness.	maday
212	e filed within 7 al Hygiene. I other than "r vent, the Med	Completed	Liementary/decondary (0-12)	5+	Sci	entist			Federal Go	vernment
pu	be file	To Be (	17. Father's Name (First, Middle, Last)						e, Maiden Surname)	
Уa	should be and Mental marked o	၉	Ludwig Selzer		401 14 77			Wofford		
Maryland 21215-0036	nd 2 sho alth and 27 Is m		19a. Informant's Name/Relationship (Ty Catherine D. Lewis		1040	ng Address ( <i>Street</i> 7 Great Ar	bor Driv	re. Poton	ber, City or Town, State, . nac, Marylan	ad 20854
a)	1 a Hei	1	20a. Method of Disposition	20	b. Place of Dispe	osition (Name of matory or other pla		Date	20c. Location - City or	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		lontgome	ry ium, Inc.	reb	. 26, 007	Bethesda, 1	Maryland
ati	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	ее	D.	2. Name and Addre	ess of Facility	Funoro	Beth	esda-Chevy
_	e a m e a		Ky		$0198 \frac{1}{7}$	557 Wisco	nsin Ave	., Bethes	1 Home/Bethorda, MD 2081	se, Inc. 4-3501
		ÿ	23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the d ne cause on each line.	eath. Do not en	ter the mode of dyi	ng, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Respirat		lure				
ľ	Examiner			Due to (or as a con: Epigloti						
	-\$ - €	Jer	Sequentially list conditions, if any loading to immediate	Due to or as a cons						
$\sqrt{}$	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o						
30,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a con:	sequence of):					
68760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	dical		1						
Вох 6	death certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre	gnancy				23d. Date of dei	ivery
	death atter	iciar	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time		□Ectopic pregnanc □ Other <i>(specify)</i> _	у		Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown	9∐Unknown						
	The law requires that ate has been signed by age 2 should be deta	by F	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		tobacco use contribute to	
Records,	requii	ted						. 10	Yes 2 No 3 Pi	obably 4 XUnknown
3ec	e law has b	Completed						24a. Was	psy prior to	topsy findings available completion of cause of
a			25. Was case referred to medical					1 Yes	2 No 1 Yes	2 🛛 No
⋚		o Be	examiner?	Hospital: 1X Inpatient 2	P □ FB/Outpatie	nt 3 DOA Oth	or:	eath (Check only	one) idence 6 □Other (Spe	-16.1
Division or Vital	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o				how injury occurred	orry)
<u>io</u>	Attending r death. ector: After by the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORTH, Day Feat	r) Injury		Yes 2 □ No			
i V	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	it home, farm, st ecify)	reet, factory, office		28f. Location ( City or To	Street and Number or Ru wn, State)	ıral Route Number,
	pltal ours at eral E		29a. Certifier 1 Chifying Phy	, sician: To the best of my	knowledge deat	th occurred at the ti	me, date and place	on and due to the	20000(a) and manner as	atota d
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my	opinion, death oo	curred at the time	, date and place, and due	to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Monta	h, Day, Year)
			1 (Sintal)	= NW			61768		February 2	20, 2007
	15		30. Name and address of person who co		Item 23a) (Type,	Print)	C: 1	Comina	Manuland 00	0010
			Fabienne Santel,	Y.D. 1500 F Registrar's Si		ten road,	orrver	spring,	Maryland 20	) <b>3 T</b> O
	Sta Registr		MAR 0 1 200	7 Janes	H Son	de				

DHMH 17 Rev 1/2001

07-01441 Gail Schwer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State	Certific	cate of Dea	ith	,	Reg. I	No.	
Physicia	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year								
Medical Examin		Gail Louise Schwe					February 21,	2007 4c. County of Death	1150 hrs
	1	4a. Facility Name (if not institution, give street and nun 4634 Parkside Drive	nber)		, Town, or Lo imore	cation of Death			
Funeral	-		. Age (In yrs. last bi		ider 1 Year	If Under 24Hrs.	8. Date of Birth(N	MM/DD/YYYY) 9 Bir	thplace (State or
Director			51	Yrs. Mon	ths Days	Hours Man.	1 7 01	Foreig	Lunder ()
	-	572-06-6541   1 M 2 X F   3 Sual Residence of Decedent	31				Feb. 21,	1956	CA
any	Ī	10a State 10b. County	10c. City, Tow	n or Location					10d Inside City Limits
and show	5	Maryland N/A	Bal	timore					1 X Yes 2 No
Maryl 28a-1	Director	10e. Street and Number		10f. Z	ip Code		10g.	Citizen of What Cou	ntry?
eath with the Maryland items 23a or 28a-f show any ust be notified at once.		4634 Parkside Drive			21206			J.S.A.	San Indian Disele
tems st be r		11. Marital Status  1 X Never Married  2 Married  Armed Fo				nic Origin? ( Spe lexican, Puerto F		White, etc.	ican Indian, Black,
er dez		1 Yes 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 Yes	2 X No s	specify:		Specify Whi	te
urs af ıtural'	함	15. Decedent's Education (Specify only highest grad-	e completed) 16a	. Decedent's Usua	al Occupation	(Give kind of wo		6b. Kind of Business/	Industry
72 ho	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)	during most of w	orking lite. D	O NOT use retire	ea)		
vithin ene.	티	5+		Teache				School School	
filed v Hygind of oth		17. Father's Name (First, Middle, Last)			18.		First, Middle, Maid		
21215-0036 muld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	B B	Charles E. Schwe	<u>r</u>	9b. Mailing Addre	ss (Street a	Mary and Number or Ru	L,ural Route Numbe	DeYoun	g , Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once	-	Linda Haven/Sister		12417 N	N. 66t	h. Ave.	Gler	ndale AZ	85304
e, Nand Land Health item	r	Linda Haven/Sister  20a. Method of Disposition		e of Disposition (Natory or other place	ame of ceme		Date 2	0c. Location - City or	
mor ages ent of nt: If		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	III State	Cremato		02/26	5/ 2007	Baltimor	e MD
Baltimore, permit Pages 1 a Department of the mportant: If it in injury or other in	f	21. Signature of Funeral Service Licensee		22 Name ar	nd Address of	f Facility		Home, Inc.	
a P S E E	$\perp$	Wint		6/	415 Re	lair Roa	ad Balti	more MD	21206 Approximate Interval
Physician Wedical	Ţ	23a. Part I. Enter the disease, or complications that ca failure. List only one cause on each line.					respiratory arrest,	SHOCK, OF HEAR	Between Onset and Death
Examiner	Ì		osclerotic (	cardiovascu	ılar dis	sease			Dodai
		Sequentially list conditions, b.	consequence or).					_	
	Je	if any, leading to immediate  Cause. Enter Underlying Cause	consequence of):						
	Examiner	(Disease or injury that initiated C.	consequence of):						
kecuted		d							
ial iai	Medical	X UNPENDED #23a,2	/,per, ME,	g865, 3/14,	/07 TI				1
760, ficate be g physic the bur			utcome of pregnand	У		Ectopic pregnar	ncv	23d. Date of deliver Month	y Day Year
K 68'	sician	past 12 months?	ant at time of death	2 Fetal dear			,		
O. Box 687 at the death certific by the attending I	≥1	1 Yes 2 No 9 V Unknown 9 Unknow					lan Billi		the same of doub?
- 2 9 9	by P	Part II. Other significant conditions contributing to	death but not result	ing in the underlyi	ing cause give	en in Part I.		cco use contribute to	bably 4 V Unknown
S, P uires th				<del></del>			24a. Was an		utopsy findings available
tal Records cian: The law requi certificate has been ector, page 2 should	Completed						autopsy	prior to	completion of cause of
Rec The la	E O						1 🗸 Yes 2		es 2 No
tal Rec cian: The certificate	Be (	25. Was case referred to medical examiner?		/Outpatient 3		f Death (Check of ther Nursing		sidence 6 🗸 Othe	r: Scene
of Viting Physical After this	리	1 ✓ Yes 2 No 28a Date		b. Time of Injury	28c. Injury		28d. Describe hov		
n of ording Ph	<u>ë</u>	1 X Natural 5 Pending (Month	Day, Year)	, ,	1 Ye	s 2 No			
Division of Vital Records, rate of Attending Physician: The law requires after death an Director. After this certificate has been selected in by the funeral director, page 2 should	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Plac	e of Injury - At home	, farm, street, facto	ory, office bui	lding, etc.			ural Route Number, City
Division  Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	erti	3 Suicide 6 Could not be determined (Specify)					or Town, Stat	e)	
Hosp 24 hou Fune rtely fi	alC	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge,	death occurred at	the time, date	and place, and	due to the cause(s	s) and manner as sta	ted.
D To the Hospital within 24 hours To the Funeral completely filled	Medical	one)  2 Medical Examiner: On the basis of and manner s	of examination and/o tated					gd. Date signed (Mo	
	Σ	29b. Signature and title of certifier	¢	1	29c. License O.C.M			February 22, 20	
		course 1	0 of de 15 (f) 00		U.U.IVI				
		30. Name and address of person who completed cause Zabiullah Ali, M.D. Assistant Medic		a) 111 Penn Str	eet, Baltin	nore, MD 212	201		
St.	ate		gistrar's Signature	hants.					
Pogie		31. Date filed (Mooth, Pay Year) Re WAR 0 1 2007	is the	THE PERSON NAMED IN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year KUSSELL 17: 31PM 200 2 /Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death tospita Baltimore, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 23 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) Year) 1 M M 2□ F 246-52. 0504 1924 ROCKYNOUNTNO Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at res 2 □ No Funeral Director INDSOR MIL 10e. Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 ☐ Divorced Year or Dates: natural Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 'EEL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES TAYLOR SR. DYNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ARGYRIE TOYLOR MCCRAY-daughter32 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. SWOOD CIRCLE WINDSORMILL, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place)

SHOWER CHARGE TERY FEB 28, 2007 ROCKYMOUNT, N.C., 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signatu Funeral Service Licent CHAPEL DC 20011 N.W. And 1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Phermonia disease or condition resulting in death) 3 day /Medical ue to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ate has been si page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perfor 1□ Yes or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Impatient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After th funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier

Parsel Alervah 29c. License number 29d. Date signed (Month, Day, Year) 02/21/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Basel Alebrahim 900 Caton Ave.

Registrar

State

MAR 0 1 2007

31. Date filed (Month, Day, Year)



ay lor, James

			1 - For State Ragistrar	State of Maryland		rtment of H			giene ()	7 06238
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		NOVA CARREEN	THOMAS				Februa	ry 25, 2	007 2:32 a M
	Examin	er	4a. Facility Name (If not institution, g				r Location of Death	1	4c. County of	
			Laurel Regional H			Laurel		T = =		George's
	Funeral			Sex 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	(, Year)	Donney Trans
	Director	}	Usual Residence of Decedent	AA 04				Apr. 1	9, 1942	Pennsylvania
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a Mar	tor	Maryland Prince	George's Lau	ırel					XX Yes 2 □ No
	death with the Maryland ims 23a or 28s-f show r natat be notified at	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	23e		9310 Hilltop Cour			2070			U.S.A.	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
9	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📉 🗱 ivorced	1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates:	1	□ Yes 2⊠ No	Specify:		Specify:	White
3-003b	hour		15. Decedent's		16a, Deced	lent's Usual Occup	ation		16b. Kind of Busi	
<u>.</u>	n ne	plet	(Specify only highest g	rade completed)	(Give	kind of work done of OO NOT use retired	during most of wor	king		
7 7	i with	Completed	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)	Mana	gement A	nalyst		Federal	Government
<u> </u>	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Las	it)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
yland	Menta Menta arked artic e	70	James Thomas				Nova R	obinette		
Mar	2 shc and is mu		19a. Informant's Name/Relationship			g Address (Street				ate, Zip Code)
≥ ~`	and lealth m 27		Carreen Denise Ko			Hilltop		-	Marylnad	20708
0	t of H If Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒️Xremation 3	Themoval noin State		sition (Name of natory or other plac	l l	Date	20c. Location - Ci	ty or Town, State
saitimore,	t. Pa tmen rtant: njury		4 Donation 5 Other (Spec			del Crem		/2007	Odenton	, Maryland
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: if Item 27 is marked other than *natural', or Items 23a or 28a-1 show any fining or other traumatic event, the Macinal Examinar mainting inciting a sone.		21. Signature of Funeral Service Lic		3	Name and Address Onaldson 13 Talbo	Funeral tt Avenue			and 20707
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. by one cause on each line.	Do not ent	er the mode of dyin	ig, such as cardiad	or respiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ventricular	Fibri	llation				Onset and Death minutes
	/Medical Examiner		resulting in death)	Due to (or as a conseque Metastatic A	ence of):	arcinoma	- Perica	ardium		
	- Adminion	e	Sequentially list conditions.	b. Due to (or as a conseque		oz oznoma	10110	ar ar an		
	led Isit	ulu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Adenocarcino	,	the Tun	~			
_	al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a conseque		che nun	9			_
g/60,	death certificate be executed e ettending physician and of for use as the burial-transit	dical		d = = =						
g	ificating phy as the	g								
ž	endin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		Ectopic pregnancy	,		23d. Date	,
	deat he ett ed for	scle	in the past 12 months? 1 ☐ Yes 2 🖾 No	4□Pregnant at time of dea 9□ Unknown		Other (specify)			Month	n Day Year
5	at the de d by the e etached	Phy	9 Unknown							
gs,	law requires that es been signed b 2 should be deta	Completed by	Part II. Other significant conditions  hronic Obstructi		ting in the ur	nderlying cause giv	en in Part I.			ute to the cause of death?  Probably 4 Unknown
ecord	s been si should I	Set						24a. Was a		re autopsy findings available
r	o <u> </u>	E						autop perfor	med? dea	or to completion of cause of ath?  Yes 2 \ \mathbb{N}_0
<u>ra</u>	ician: Th certificate rector, pag	0	25. Was case referred to medical		-78		26. Place of Dea	ith (Check only or		1103 ZIAINO
2	d is	To B	examiner? 1 ☐ Yes 2∑∑Vo	Hospital: 1XXInpatient 2 E	R/Outpatien	t 3□ DOA Oth			ence 6 □Other	(Specify)
0	ding Pt After th funeral		27. Manner of Death 1 ⚠ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	28d. Describe h	ow injury occurred	
<u>S</u>	age : e	atle	2 ☐ Accident investigate				Yes 2 □ No			
DIVISION	or Attendate after death	Certification:	3 Suicide 6 Could not 4 Homicide determine		ne, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number.
_	Hospital 24 hours a Funeral C		29a. Certifier 1 Cartifying I	Physician: To the best of my knowl	ledge, death	occurred at the tin	ne, date and place	, and due to the	ause(s) and mann	er as stated
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Madical Expone)	aminar: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	pinion, death occu	rred at the time, o	date and place, and	d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1-110		29c. Licens	e number		29d. Date signed (	Month, Day, Year)
			Mullan	1 T War	Val	(ا۔ را	1391	6	02/20	5/2007
	P		30. Name and address of person wh William A. W			Print) Ce George	e Street,	Laurel	, Marylar	d 20707
i	Sta	ite	31. Date filed (Month, Day, Year)	22. Registrar's Signatu		00 -				
	Registr	ar	MAR 0 1 20	07 Marie St	GOBA					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 10:40 M Evelyn Thompson 24 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1600 W. Mt. Royal Avenue Baltimore er 1 Year 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1□M 2🄼 F Min. Yrs. 226-32-0085 80 5 9 1926 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 W. Mt. Royal Avenue 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unknown Grempler Reality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Gresham Robert Lee Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 N. Bernice Avenue Baltimore, MD 21229 Ellen Taylor-niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/5/07 VΑ West Point Sunny Slopes Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Worren 1101 Avenue Baltimore, North MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of)

**Physician** /Medical Examiner

requires that the death certificate be executed

attending

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certificate has

Box 68760

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

show

r 28a-f sh notified

"natural", or items 23a or dical Examiner must be r

the Medical

marked other than

9

Department of Health ar Important: If Item 27 Is any Injury or other trau

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner and I-transit

physician ar s the burial-t Physician/Medical as for use signed by t d be detach 2 page 2 should Completed funeral director, Be ဥ After this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director; After ti completely filled in by the funera Certification:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 🗌 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ Mo

IF FEMALE:

Due to (or as a consequence of) Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 ☐ Other (specify)

Month

autopsy performed? Yes 2 No

28d. Describe how injury occurred

24a. Was an

1□ Yes

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

23d. Date of delivery

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 🗌 Yes

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature a

29c. License number

29d. Date signed (Month, Day, Year) 27 0

30. Name and address of person who completed caus ondeath (Item 23a) (Type, Print) pYKal Johns Hopki NS

31. Date filed (Month, Day, 2007 egistrar's Signature

h

State

Registrar

			For State Registrar	State o	f Maryla	-	artment of Hartificate of		Mental Hyo	giene () ( Reg. No.		06240
			1. Decedent's Name (First, Middle, I	.ast)					2. Date of Dea		V	3. Time of Death
	Physici		Geretha	I.	T	urner			2 14	1 <sup>Day</sup> 2007	Year	7:45p.m. <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and nui	mber)		4b. City, Town, o	r Location of Dea	ath	4c. County	of Death	<u> </u>
	LAGITI		Joseph Richey	Hospice	<u>,</u>		Balti	more		N/	/Δ	
	Funeral			Sex		s. last birthday)	If Under 1 Year	If Under 24 Hi	s. 8. Date of Birtl	1	9. Birth	place (State or Foreign
	Director		214-24-1840	1□ M 200 F	81	Yrs.	Months Days	Hours Mir	n. (Month, Da)	1925	Con	N.C.
	7		Usuel Residence of Decedent						1			11.01
	ylan how		10a. State 10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Ma-1-	to	MD Bal	timore		Reister	stown					1 ☐ Yes 2 🔼 No
	라 다 28 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	13 with wi		304 Cantata Co	ourt Ap	t. 415		211	36		USA		
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.1	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	e - Amen	can Indian,
ထွ	or its	E	1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	2 🚰 No		1 ☐ Yes 2 <mark>X</mark> No	Specify:	,	Specify		
2	ours iral',	d by	3 ☐ Widowed 4 XX Divorced	Year or D						- Opecin)	Bla	ick
'n	72 h	Completed	15. Decedent's (Specify only highest of			(Give	lent's Usual Occup kind of work done	during most of w	orking	16b. Kind of Bu	isiness/lr	ndustry
2	ithin	ig	Elementary/Secondary (0-12)	College (			DO NOT use retire					
2	flied within 72 hours after death with the Maryland Hygiene. Other than "natural", or iteme 23a or 28a-f ehow ent, the Medical Examiner must be inclified at		12th	N/A	1	Data	Input Cl		(Cinn Ministr	Social		rity
2	be fi	Be	17. Father's Name (First, Middle, La						ame (First, Middle,		•	
aryland 21215-0036	ould Mer Parke	ပို	James		ngram	14		Lula		Wall		
Ja	2 sh and I or raum		19a. Informant's Name/Relationship						Rural Route Numbe			
<u>a</u>	and lealth m 27 her t		Dorothy Jackson	-niece	200		Highoak	Road G1	en Burnie		2106	
5	T of H		20a. Method of Disposition 1-12 Burial 2 ☐ Cremation 3	☐Removal from	State	cemetery, crer	natory or other pla			20c. Location -	-	
altimore,	men tant: jury		4 □ Donation 5 □ Other (Spe		W		Cemeter		21/2007 E	Baltimor	e.	MD
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Inportant: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination relationships at Once.		21. Signature of Funeral Service Lic	ensee		22	. Name and Addre	ess of Facility	IARCH FUNE	CRAT, HOM	E-ΕΔ	ST
ш_	40 E # 9		23a. Part1. Enter the disease, or co	e W	ane	$\omega$	101 E. N					21202 Approximate
н			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that on the confidence on the confid	aused the dea	ath. Do not enl	er the mode of dyli	ng, such as cardi	ac or respiratory are	rest,		Interval Between
	Physician		Immediate Cause (Final disease or condition	. no	mm	w he	.2	ShoK	Q			Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse	equence of):	1					
	Examiner		Sequentially list conditions,	b. h	1 per	tensi	m					YPOV 5
	- W=	ner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to.	as a conse		11 4	•				,
	nd /	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c. ar	nal		ollati	S				YELVS
Ö,	e exe		resulting in death) cast	Due to	(or as a conse	equence of):						
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and agge 2 should be detached for use as the burial-transit.	dicai	,	d								
9	ing p		IF FEMALE:								1	
စ္ထိ	w requires that the death certific been signed by the attending f should be detached for use as	iclan/Me	23b. Was decedent pregnant in the past 12 pronths?		oirth 2 ☐ Fe	tal death 3	Ectopic pregnanc	y		23d. Dat Mo	e of deliv	ery Day Year
Vital Records, P.O. Box	the a	sic	1 ☐ Yes 2 € No 9 ☐ Unknown	4∐Pregr 9∐Unkn	nant at time of own	death 5	Other (specify) _			1.00		Day Tour
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Ś	igner igner bed	Š	Part II. Other significant conditions	s contributing to a	eath but not re	esuiting in the u	nderlying cause giv	en in Part I.				the cause of death?
ב	equir sen s ould	ted							. 1UY	es 2 No	3 Pro	bably 4 ⊠Unknown
ပ္ပ	has be	Completed							24a. Was a autop	an 24b. \	Nere auto	opsy findings available ompletion of cause of
Œ	ysician: The is certificate hu director, page	no.							perfor	med2 d	leath?	2□ No
a	iclan: Th certificete rector, pag	Bec	25. Was case referred to medical					26. Place of D	eath Check only or	and the same		
<b>&gt;</b>	Physic this ce al direc	To	examiner? 1 🗆 Yes / 2 🖫 No	Hospital:	Inpatient 2(	ER/Outpatier	it 3□ DOA Ott	ner: 4 🗌 Nursing	Home 5 Resid	ence 6 Oth	er (Speci	W HOSOICO
Division of	ding Ph h. After th funeral	Ë	27. Man r of Death 1 ✓ Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	28c. Inju	ry at	28d. Describe h	ow injury occurr	ed	
ō	ttendir deeth. stor: Af the fur	atic	2 Accident investigation	ion	, ,			Yes 2 □ No				
<u> </u>	or de	ertification;	3 Suicide 6 Could no 4 Homicide determine	ad 286. Place	of Injury - At		eet, factory, office		28f. Location (S City or Tow		er or Rur	al Route Number,
ā	talo is eft ed Di	Cer				<u> </u>			16	, 51,		
	hour hour uner		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	best of my kr	nowledge, deat	occurred at the ti	me, date and pla	ce, and due to the c curred at the time, o	ause(s) and ma	nner as s	stated.
	To the Hospital or Attending Physician: within 24 hours effer deeth. To the Funerel Director: Affer this certific completely filled in by the funeral director.	Medical	one)	and man	ner stated.							
	To t To t	Σ	29b. Signature and title of certifier	2		00	29c. Licens	VC 71	1111	29d. Date signed	1	_
	7.		(Cachel)	5		JN1)	DC	US TE	747	2	15/0	7
	10	_	30. Name and address of person wh	o completed caus	se of death (Ite	ет 23а) (Туре,	Print)	1 >			D	a Ithner (MI)
_	1		Kachelleune	5200 8	caster	n Ave	vue W	ILT BI	2 Juit	1 530	o to	21224
,	Sta		31. Date filed (Month, Day, Year)	32.	egistrar's Sigi	nature	met I		3			21224
	Regist	rar	MAR I	2007   🔏	Salar .	10.	No. of Contract of					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Robert J. Willard a M 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square 5. Social Security Number 6. Hospita Deda 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1 ★ M 2 🗆 F Months Days Hours 243-54-6312 8-2-1938 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 S. Grundy St. 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seidman Glass 12th Glazer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Robert Willard Helen Louise Collins 19a. Informant's Name/Relationship (Type. Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 S. Grundy St., Baltimore, MD 21224 Dorothy J. Willard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/2007 Baltimore, Maryland Dulaney Valley 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. Conkling St.Baltimore, MD 21224 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spiratory 1/2 hour disease or condition

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at anotes.

been signed by the attending physician and should be detached for use as the burial-transi has this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner Be

Certification: To

Medical

31. Date filed (Month, Day, Year)

MAR 0 1 2007

within 24 hours a

To the Funeral I State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	flung sood three	m+	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed' 1  Yes 2	
25. Was case referred to medical examiner? 1 ☐ Yes 21 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othor	eath <i>(Check only one)</i> Home 5 \( \subseteq \text{Residence} \)	6 DOther (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation			28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one)  1. Certifying Ph 2 Medical Example 1	ysician: To the best of my knowledge, deat niner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place overstigation, in my opinion, death occurred.	ce, and due to the cause curred at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and tyle of certifier	they as mo	29c. License number	29d. [	Date signed (Month, Day, Year) $2 - 27 - 07$
30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print) Quare Drive Ba	Himore, M.	d 21237

DHMH 17 Rev 1/2001

32. Registrar's Signature

		1	For State Registrar	State of Ma	ıryland		partment of H <i>ertificate of l</i>		Mental Hy	giene Reg. No.	007	06242
Diversi		_	1. Decedent's Name (First, Middle, Las						2. Date of De		Year	3. Time of Death
Physi /Med		1		a B. Winde	er				Februar	ry 20	, 2007	2:30 A M
Exam	ine	r '	la. Facility Name (If not institution, give Rockville Nursing				4b. City, Town, or Rockvil		:h		County of Deat ntgome:	
Funera	al		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	st birthda		If Under 24 Hrs Hours Min.			9. Birt	thplace (State or Foreign
Directo			308-48-23/1	□M 2፟M F	89	Yrs.	World's Days	riours IVIII.	November	30, 19	17 Mic	higan
land ow		-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or	Location					10d. Inside City Limits
a-fah	1	201	Florida Lee			C	ape Coral					1 Yes 2 No
or 28	1	e C	10e. Street and Number				10f. Zip Code				en of What Co	•
eath v	1	runeral Director	1414 S.W. 20th St	12 Was Decedent F	ver in U.S	1:	33991	spanic Origin? (5	Specify Yes or No		ited St	
DERITINGTE, INTERVIENT A L L 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "netural", or Itama 23s or 28s-f show any injury or other traumatic event, the Medical Energing must be notified at		<u>~</u>	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puer Specify:	to Rican, etc.)		Black, Whit	
ithin 72 ho		Сощрієте	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		+)	(Gi life	cedent's Usual Occupative kind of work done of the DO NOT use retired	ation furing most of wo )	rking		nd of Business	Andustry
Hygien thar th	3		17. Father's Name (First, Middle, Last)	4		Нот	nemaker	18. Mother's Na	me (First, Middle		n Home	
yfand buld be file Mental Hy arked oth	6	0 0	Joseph Bursley						ry Knowl		,	
ary shou and M is mar	1		19a. Informant's Name/Relationship (		11.		ailing Address (Street a			-		
and and and and and and and and and and		-	Joseph A. B. Wind	er / Son	John Bla		00 Long Pin					
Daltimore Dermit. Pages 1 Department of H mportant: If Ita			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	1)	Cer	netery, c comency	rematory or other place Crematorium,	Inc. 24,	2007	Beth		Maryland
Departiment in portion			21. Signature of Funeral Service Licer	unal	M013	305	22. Name and Address Robert A. Pum 300 West Mont	prey Funer gomery Ave	cal Home/I	Rockvi ville,	lle, Inc Marylan	d 20850–2805
	ı		23a. Part1. Enter the disease, or com shock or heart failure. List only	olications that caused one cause on each lin	the death. ne.	Do not e	enter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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icate be executed physicien and sthe burial-transit		dical		d. Dement	tia							
D E ON	- 1.4	D)  -	IF FEMALE:	23c. If yes, outcome	of pregnan	cy				2	3d. Date of del	iven.
		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□ Unknown			3 □Ectopic pregnancy 5 □ Other (specify)				Month	Day Year
		2	Part II. Other significant conditions o	ontributing to death b	ut not result	ting in the	a underlying cause give	en in Part I.	i			o the cause of death?
HeC The law te has bage 2 sl		Сощріете							24a. Was auto perfe 1 Yes	psy ormed?	death?	utopsy findings available completion of cause of
Or VITAL P Physician: Th rthis certificate ral director, pag	319	e n	25. Was case referred to medical examiner?	Honoital	1.15		1 04		ath Check only			
this ald	112	2	1 ☐ Yes 2 🔯 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpat 28b. Time	e of 28c Injun	or: 4 ⊠ Nursing b	dome 5 ☐ Resi	idence 6	Other (Spe	cify)
nding ath. r: Afte		TION	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year)	Injun	y Worl	(? Yes 2 □ No	255. 55551.55		30001100	
DIVISION OF all or Attanding Physical after death. I Director: After this din by the funeral of		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, farm,	street, factory, office		28f. Location ( City or To		Number or Ru	ural Route Number,
UIV To the Hospital or / within 24 hours after To the Funeral Dirac		edical	2 va. Conflier (Check only one) 1  Certifying Photosome 2  Medical Example 1  Medical Exa	yaician: To the best s niner: On the basis of and manner sta	examination	ledga da on and/or	eath occurred at the tin investigation, in my of	ia, date and plac pinion, death occi	e, and due to the urred at the time,	date and	and manner as place, and due	to the cause(s)
To th withir To th comp	1	M	29b. Signature and title of certifier		C		29c. License	number		29d. Date	signed (Mont	h, Day, Year)
			Moma		100%	-	·	47330		Febr	uary 22	2, 2007
8			30. Name and address of person who Thomas V. Joseph,					#207 <b>,</b>	Rockvi1	1e, M	arylan	d 20850
S Regi	Stat	-	31. Date filed (Month, Day, Year) MAR 0 1	32. Aegistra		igo	parte					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1- State Amend #20b, perFH, G865, 3/1/07 T.	Cer	tificate of	leaith and M Death	ental Hygie Reg	ene 007	06243			
	Physicia		1. Decedent's Name (First, Middle, Last)  BLANCHE	WOL	_FSON		2. Date of Death	26, 2ďď	3. Time of Death 3:25 P M			
·	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	.1			
			5833 PARK HEIGHTS AVENUE #307		WIL 1 1 2 2	BALTIMOR			N/A			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 89  Usual Residence of Decedent	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 4/13/191	rear)   Cour	place (State or Foreign htry) MD			
	aryland show	J.	10a. State 10b. County 10c. City	Town or Loc				1	10d. Inside City Limits  1) Yes 2 □ No			
	the M 28a-f notifie	Director	10e. Street and Number		10f. Zip Code		100	10g. Citizen of What Country?				
	th with 23a or 1st be		5833 PARK HEIGHTS AVENUE #307		2121		U.S	•				
900	be filed within 72 hours after death with the Maryland ntal Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give ✓ Year or Dates:		Vas Decedent of H f Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:				
15-(	n 72 h "natu edica	lete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life. D	lent's Usual Occup kind of work done DO NOT use retired	oation during most of worki d)	ng   16	6b. Kind of Business/In	dustry			
212	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		MAKER			OWN HOME				
Maryland 21215-0036	should be filed and Mental Hygis marked other imatic event, tl	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN LE	EVIN		18. Mother's Name	(First, Middle, Ma	aiden Surname) SAC	HS			
lary	is at		19a. Informant's Name/Relationship (Type. Print)		-			City or Town, State, Zip	•			
e, N	1 and lealth em 27 ther tr		ELLEN ARVIN / DAUGHTER  20a. Method of Disposition 20b. Pl		COCKEYS Notice of Name of			RSTOWN, MD				
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	JACOB	cong.	<sup>ce)</sup> 2/28/200 12/28	07 8 <del>/2007</del> F	INKSBURG,	MD			
Bal	permit Depar Impor any Ir once,		21. Signature of Funeral Service Licensee		Name and Addre	30		SON & BROS. PIKESVILLE,				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cruse on each line.  Immediate Cause (Final disease or condition resulting in death)  a	Do not ente				st,	Approximate Interval Between Onset and Death			
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence									
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P.O. Box	that the death certined by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliver	ery Day Year			
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to to				
Il Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of			
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		Oth	26. Place of Death	\ /	)				
o	S (0 =	. To	1 Yes 2 No 1 Inpatient 2 It Inpatien	ER/Outpatien 28b. Time of		4 🗆 Nursing Hor		nce 6 Other (Special	5/)			
on	Attending r death. ector: After oy the fune	tion	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation									
Division	al or Attending Phy s after death. Il Director: After this ed in by the funeral c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At no building, etc. (Specify	me, farm, stre	eet, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,			
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know one) 1 Medical Examiner: On the basis of examinat and mahner stated.	my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  camination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the within To the Comp	Me	29b. Signature and title of certifier  M. Xn M	29c. License number 29d. Date signed ( <i>Month, Day, Year</i> ) 2/27/2007								
30. Name and address of person who completed cause of death (Item :					2 243	M IN 7	Belocate	re 21)	15			
State Registrar MAR 0 1 2007					de			-10				
			22.67 75 7	- 5								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, 2007 **Physician** February Rosalie 2:00PM Μ. Zivec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Somerford Assisted Living 8. Date of Birth
(Month, Day, Year) Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Months Days Hours Min 81 Director 218-12-8820 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Glen Burnie 1 ☐ Yes 2 ☐ No MD Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 304 Baylor Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No White <u></u> 3 Widowed 4 □ Divorced "natural", Year or Dates Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Inspector Westinghouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nolan J. Hurley Christine T. Frederick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Earl Hurley/ Nephew 304 Baylor Road Glen Bunrie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If it any injury or c March 2. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Louden Park Cemetery 4 Donation 5 Dother (Specify) 2007 Baltimore, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liuc **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.O. | ed by the a 1 Yes 2 NO 9☐Unknown 9 Unknown sate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 🗆 No 1 ☐ Yes 1□ Yes 2☑ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**□** No 2 ☐ ER/Outpatient BSUBLECT ို 1 Inpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 5 Pending To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 01

2007

30. Name and a

394

ress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

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				Registrar  1. Decedent's Name (First, Middle, La	act)		Cert	ilicale of	Dealli	2. Date of Dea	eg. No.	3. Time of Death	
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	P			Usual Residence of Decedent		100 City	Town or Loc	ation				10d. Inside City Limi	its
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_	and and	is m		19a. Informant's Name/Relationship					and Number or Rur				
	and and ealth	m 27 nar tr		Joetta L. Andrew	/Daughter	20h BI			venue, Ha	gerstown Date		ZI/40 City or Town, State	
Joseph	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.	If ite	1	20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3	☐Removal from State			ition (Name of atory or other pla				•	_
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8 ptc	Ivision of Vital Records, P.O. Box 68760, <mr></mr> r Attending Physicien: The law requires that the death certificate be executed to recognize the death.	iractor. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d	ine.  a consequ  a consequ  a consequ  a consequ  b of pregna  2   Fetal  at time of de  but not resu  ury  ay Year)	Do not enter the control of the cont	DI Penns or the mode of dyi  MC C VVL  Ectopic pregnanc Other (specify) _ Inderlying cause gi	yIvania Ang, such as cardiac  y  y  y  y  y  y  y  y  y  y  26. Place of Dea  her: 4 Nursing H  ry at  rk?    Yes 2 □ No	23e. Did to 1 \( \) 24a. Was autop perfo 1 \( \) Yes th (Check only o ome 5 \( \) Residence 28d. Describe for the content of t	23d. Da Mc  bbacco use cont (es 2 \( \) No  an  sy rmed? 22 \( \) No  dence 6 \( \) Oth now injury occur  Street and Numb	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death Onset of Death Onset (Specify)	2
8 pt	Ivision of Vital Records, P.O. Box 68760, <mr></mr> r Attending Physicien: The law requires that the death certificate be executed to recognize the death.	iractor. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as c. Due to (or as d	a conseque a conseque a conseque a of pregnal 2 Fetal at time of de but not resulting ay Year)	Do not enter  Do St.  Lence of):  Lence of	Ectopic pregnance Other (specify)	yIvania Ang, such as cardiac  y  y  y  y  y  y  y  y  y  y  y  y  y	23e. Did to 1 24a. Was autop performe 5 Residence 28d. Describe for City or Toy	23d. Da Mc  bbacco use cont (es 2 \( \) No  an isy rmed? 22h.  chence 6 \( \) Ott now injury occur  Street and Number, State)	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset and Death Onset on Ons	2
8 pt	Ivision of Vital Records, P.O. Box 68760, <mr></mr> r Attending Physicien: The law requires that the death certificate be executed to recognize the death.	iractor. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	shock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to incinediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a conseque a consequence a consequen	Do not enter  Do St.  Jence of):  Jence of of of the leaf of the l	Ectopic pregnance Other (specify)	yIvan1a Ang, such as cardiac  Pulmed  y  ven in Part I.  26. Place of Dea  ther: 4 Nursing H  ry at  rk?  Yes 2 □ No	23e. Did to 1 Yes  24a. Was autoport of the Check only of the Chec	23d. Da Mc  bbacco use conf  (es 2 No  an esy 24b.  an esy 24b.  cause(s) and mark  cause	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on Onset and Death Onset on Ons	2
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3

Muhammad Waseem
31. Date filed (Month, Day, Year)
MAR 0 1 2007 State Registrar

1126 Opal Court, Hagerstown, Md. 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State Registrar Amend #5	State of Man Per Fh g86				nd Mental Hy		007	06246
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Dana Abbe					2. Date of De		Year	3. Time of Death
	/Medic	al .				41. Oh. T.		02	06	2007	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	Examin	er	4a. Facility Name (If not institution, give s	Mwyland		200	n, or Location of	Death		ounty of Deat	note City
		5)	5. Social Security Nactor 6. Sex		yrs. last birthday)		ar If Under 2	4 Hrs. 8. Date of Bir			hplace (State or Foreign
	- Funeral Director		2168 <del>8-861</del> 2	<sup>M</sup> 2□F 3		Months Da	ys Hours	Min. 8. Date of Bir (Month, Da	y, Year) 1968	Co	RYLAND
	and *	}	Usual Residence of Decedent  10a, State 10b, County	10	Oc. City, Town or Lo	ocation					10d. Inside City Limits
	Aaryli e e e	ŏ	MD CAROL	TNE	וסט	DERALSBI	TDC				1 Yes 2 No
	the the 286-	Director	MD CAROL  10e. Street and Number	INE	1, 171	10f. Zip Cod			10g. Citize	n of What Co	untry?
	With 3a or		101 PORTER COURT				21632			US	SA
	me 2	Funerai		2. Was Decedent Eve	r in U.S. 13.	Was Decedent	of Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	- 14.	Race - Ame	
9	or ite		1 Never Married 2 Marned	Armed Forces?  1 Yes 2 No		1 Yes 2 X		Puerto Hican, etc.)		Black, White	
03	hours after death with the Maryland tural', or tteme 23a or 28e-f ehow at Examiner must be notified at	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 105 2	но зресну.		51	pecify: WE	IITE 
21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Oc kind of work do	ne during most	of working	16b. Kind	of Business/	Industry
121	within ene.	Id III	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use re			CON	CITATION	TON
	be filed withital Hygiene. d other then		17. Father's Name (First, Middle, Last)	0	DKI	WALL HAI		's Name (First, Middle		STRUCI	.TON
an	b d la b	To Be	GUILFORD ABBOTT, J	R.			DON	NA PARKINS	ON		
Maryland	2 should and Men le marke reumatic	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Str	reet and Number	or Rural Route Numb	er, City or T	own, State, 2	Zip Code)
S	tra tra		DONNA ABBOTT/MOTE	ER	243	14 RICHA	ARDSON F	ROAD, FEDER	ALSBU	RG, MI	21632
ē,	es 1 an of Heal fitem 3 r other		20a. Method of Disposition		20b. Place of Dispo		f	Date		tion - City or	
altimore,	Pag nent nt: f		1  Burial 2  Cremation 3  R 4  Donation 5  Other (Specify)	emoval from State	-			2/12/2007	EAST	ON, MA	ARYLAND
alt:	permit. Par Departmen Important: eny injury		21. Signature of Funeral Service License	е	2	2. Name and Ad	dress of Facility	BEIN & NEWN	IAM 12TI	MEDAT	HUME DY
m	89 5 8		JEHO R.	MERCER		00 S. H	ARRISON	ST EASTON,	MD 2	1601	HOTE FA
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not en	ter the mode of	dying, such as c	ardiac or respiratory a	rrest,		Approximate fnterval Between
	Pnysician		fmmediate Cause (Final disease or condition	Wester	20.0						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						2 4 2 2 4 4
	Examiner		Sequentially list conditions, b	mesen	tulic 15	chemi	4				Zuels
	ed isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c		1 27	-				Zuels 5415
_	and all-trar	xan	that initiated events resulting in death) Last	Due to (or as a c		diom	12 bein			-	3973
760	eath certificate be executed attending physician and for use as the burial-transit	calE									
687	ficate phys		<b>\</b> d	•							
Box (	certii nding use a	Z/M	fF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of g		-			230	I. Date of def	ivery
	death a atte	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pregna □ Other (s <i>pecif</i> y				Month	Day Year
P.0	that the de led by the a detached t	Physician/Med	9 Unknown	9 Unknown							
	The law requires that the death certificate be executed as bean signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	underlying cause	given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ğ	w require been sig	ed	Hepahhs C		<u>.</u>			1	Yes 2 □ I	4o 3 <b>∃</b> • r	obably 4 Unknown
Records,	has be	Completed by	1					24a. Was		24b. Were au	topsy findings available completion of cause of
	ysician: The is certificate hadinector, page	Son						perfo	rmed?	death?	2□ No
/ita	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?					of Death (Check only	ne)		
of Vital	Physician: rthis certifice ral director, p	၉	1 Yes 2 No	1	2 ER/Outpatie	111 30 DOX		sing Home 5 Resi			cify)
	ding Ph h. After th funeral	lo lo	1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	1	lnjuryat Work? 1 ∐ Yes 2 ∐ N	28d. Describe	now injury o	ccurred	
Division	death ctor: y the	lical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, st				Street and N	lumber or Ru	ıral Route Number.
Θ	after Dire	Certification:	4 Homicide determined	building, etc. (	Specify)			City or To			,
_	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phys	icien: To the best of n	ny knowledge, deal	th occurred at th	ne time, date and	I place, and due to the	cause(s) an	d manner as	stated.
	n 24 ( n 24 ( he Fu	Medical	(Check only 2 Medical Examin	ner: On the basis of ex and manner stated	amination and/or in	nvestigation, in r	ny opinion, death	n occurred at the time,	date and pl	ace, and due	to the cause(s)
	To ti Withi To ti	Σ	29b. Signature and title of certifier	$\bigcirc$			cense number				h, Day, Year)
			トノてき	ller	MD	Do	00620	130	FU	- 06	, 2007
	1		30. Name and address of person who con			2 S. C	neine	St. B	ult.	, MD	21201
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 2 200	32 degistrar's	Signature						

			- For	epartment of Health and N Certificate of Death	Mental Hygiene Reg. No.	2007 00247
N.			negistrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Robert L. Allen		February Day	13,2007 9:13p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
1	Examini	GI.	Union Hospital	Elkton	C	eci1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth (Month, Day, Yea <u>r)</u>	9. Birthplace (State or Foreign Country)
	Director		077-36-4489	S. World Days Flours Will.	January 7	,1946 NY
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	ur Location		10d. Inside City Limits
	aryla shov d at	<u>-</u>	1			1 ☐ Yes 2 ☐ No
	he M 28a-f otifie	Director	MD Cecil Elkto	10f. Zip Code	10g Citiz	zen of What Country?
	a or 2		4 John Adams Lane	21921	Tog. Oill	U.S.A.
	eath ns 23 must	eral	11 Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S		14. Race - American Indian,
20	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examiner must be notified at	by Funeral	Armed Forces?  1 □ Never Married 2 □ Married   1 □ Type 2 □ No   1 □ Type 3 □ Type 3 □ No   1 □ Type 3 □ Type 3 □ No   1 □ Type 3 □ Type	If Yes, specify Cuban, Mexican, Puèrt  1 ☐ Yes 2X No Specify:	o Rican, etc.)	Black, White, etc. Specify: Black
-CI	ייס 72 hour "natural" edical בי		15 Decedent's Education 16a, D	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	king 16b. Kir	nd of Business/Industry
Maryland 21215-0036	filed within 72 Hygiene. other than "nal ent, the Medics	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	Banker		nking
and	l be fil ntal H ed otl	Be o	Robert Allen		.ly Jones	Surname)
Ž	ges 1 and 2 should be it of Health and Mental If item 27 is marked oor other traumatic eve	은		Aailing Address (Street and Number or Ru		r Town, State, Zip Code)
<u> </u>	id 2 sho Ith and 27 is ma traum		1 1 7 7	4 John Adams Lar	-	
ō,	Health tem 27 i	1 9	20a Method of Disposition 20b. Place of D	isposition (Name of		cation - City or Town, State
Baitimore,	permit. Pages Department of I Important: If ite any Injury or of		1 □ Burial 2 □ Cremation 3 Demoval from State 4 □ Donation 5 □ Other (Specify) Hockes	ssin Crematory	uary 15, 2007	Hockessin, DE
pa	Depar Impor any Ir		21. Signature or University Service Licensee	22. Name and Address of Facility Andrew G. Gee F	uneral Ho	me MD 21921
		10	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Atty Direce	4	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)			
	LXammer	_	Couperniany list conditions, if any leading to immediate Due to (or as a conseque le of)	Atty Visterie		1489.5
	be:	nju	Gause (Disease or injury	177		1.00
•	and al-trar	Examiner	that initiated events c	*		
8/60,	ficate be executed g physician and ts the burial-transit	dical E	d			
200	fficate g phy as the	0				
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
J.	v requires that the debeta spen signed by the should be detached	F.	Part II. Other significant conditions contributing to death but not resulting in ti	he underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
gg	sign d be	d by			1 ☐ Yes 2[	□ No 3 □ Probably 4 □ Unknown
် ပ	w req	Completed			24a. Was an	24b. Were autopsy findings available
Ě	sician: The law certificate has t irector, page 2 s	dmo			autopsy performed?	prior to completion of cause of death?
<u> </u>	in: T ifficati or, pa		25. Was case referred to medical	26 Place of De	1 Yes 2 Mo ath (Check only one)	1 ☐ Yes 2 ☐ No
>	/sicia s cert	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other:	Iome 5 ☐ Residence	6 Other (Specify)
ō	g Phy erthi	n: To	27. Mann- of Death 28a. Date of Injury 28b. Tir	me of 28c. Injury at	28d. Describe how injury	
<u></u>	ath. It. Aft	atio	1 ✓ atural 5 ☐ Pending (Month, Day Year) Inji 2 ☐ Accident investigation	M 1 Yes 2 No		
<u>    S</u>	r Atte er dez recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
Ξ	talon rs afte al Di	Ser			,	,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examlner: On the basis of examination and/and manner stated.			
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Dat	e signed (Month, Day, Year)
			I A A A A A A A A A A A A A A A A A A A	DS6811	2-1	114/07
	15		30. Name and address of person who completed cause of death (Item 23a) (T.	ype, Print) 2/97	21	
	Sta	at <u>e</u>				
	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

		,	For State Registrar		St	ate of M	larylan	•	artmen rtificat				lental Hy	giene	400	Ţ.		248
	Physici		1. Decedent's Name EDWARD BA										2. Date of De	eath Par 13	2007	yr		of Death
>	/Medic Examin		4a. Fecility Name (/ PRINCE GI							Town, or	Location of	of Death		PR	County of Di		RGE'S	3
	Funeral Director		5. Social Security N 578-60-07	721	Sex 1∏ M			ast birthday) 62 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit 02-12-	1946	9. E WAS			or Foreign DC
	riand ow		Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	ocation							100	d. Inside	City Limits
	Be-f sh	ctor	MD	PRINCE	GEOR	GE'S	CA	PITOL	1						\		71	s 2 No
	sa or 2	1 Dire	10e. Street and Nur 1408 EDGI		ENUE				10f. Zip					10g. Cit	izen of What	Countr	y?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any Injury or other treumatic event, the Musical Exertif at finial be notified at once.	by Funeral Director	11. Marital Status 1  Never Marri 3  Widowed	ied 2 Married	I A	Vas Deceden Armed Forces Yes 24 Yes, Give Year or Dates	2 No	1	Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-	14. Race - Al Black, W Specify: F	hite, et	c.	
21215-0036	within 72 ho iene. r then "natur ine Medical	Completed	(Spec Elementary/Secc I 2 T	15. Decedent's cify only highest on the production of the control of the control of the city of the ci	grade con		r 5+)	16a. Dece (Give life. SAFET	kind of wo DO NOT u	rk done d se retired	during mos ()	t of work	ing	OSH	ind of Busine	ss/Indu	istry	
Maryland 2	should be filed nd Mental Hygi r marked other umatic event, II	To Be C	17. Father's Name WILLIAM I	, , , , , , , ,	st)						CHAR	LESE'	e (First, Middle	HOLS	ON			
Mar	nd 2 should lith and 27 is m		19a. informant's Na ANGELA M						_				al Route Numb ASHINGT				code)	
Baltimore,	Pages 1 ar nent of Hea nt: If item;		20a. Method of Dis 1 XBurial 2		□Remo		20b. P	lace of Dispo emetery, crer HINGTO	sition (Nar natory or o N NAT	ne of ther plac 'IONA	θ) AL (	02/1	9/2007	20c. Lo	CLAND,	or Tow MD		
Balti	permit. Departm Importe any Inju		21. Sign are of Fu	Ineral Service Lic	ensee	nen	sha						SHALL'S UITLAND				8	
	Physician		Immediate Cause disease or condition	irt failure. List on (Final	ly one ca	use on each	line.						or respiratory a		Disea		Approxim nterval B Onset and	etween
	/Medical Examiner		resulting in death)	- 1		Due to (or a	is a consequ	uence of):										
0,	ate be executed hysician and the burial-transit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	nmediate erlying injury s Last	b. — с.	Due to (or a	is a consequ											
68760,	cate be physici s the bu	edicai			d													
O. Box 6	he death certifica the attending phi ched for use as th	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Test 2 December 2	months?	1	f yes, outcom □Live birth I□Pregnant I□Unknown	2 Fetal at time of de	death 3[	]Ectopic pi ] Other <i>(sp</i>		-				23d. Date of o Month		/ Jay	Year
ecords, P.	requires that the de een signed by the a nould be detached t	by	Part II. Dther signi	ficant conditions	s contribu	iting to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I			tobacco i	use contribute	to the		death?
$\mathbf{x}$	The law ate has b page 2 st	Completed			-								24a. Was auto perfe 1  Yes		death	o comp	y finding pletion of	s available cause of
Vital	Physician: The this certificate al director, pages	o Be	25. Was case reference examined?		Hospi	tal: 1 □ Inpa		ER/Outpatier	20100	Othe			h (Check only		C [] ()			
of	fter Inel	<b>—</b>	27. Manner of Dear	th 5 Pending investigat	tion	Ba. Date of In (Month, E	iury	28b. Time o Injury		8c. Injun			me 5 Res 28d. Describe			рөспу)		
Division	spital or Atte ours after de nerel Directo filled in by th	Certification:	3 Suicide 4 Homicide	6 🗌 Could no determine		Be. Place of I building,	njury - At ho etc. <i>(Specif</i> )	ome, farm, sti	reet, factor	, office			28f. Location ( City or To			Rural I	Route Nu	mber,
	To the Hospital or Attendi whein 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer:		of examinat											(s)
	To	Σ	29b. Signature and	title of certifier	1	10	1	Des			number	-6 1	7		te signed (Mo			
	(B)		30. Name and add	ress of person wt	no compl	ed cause of	death (Item	23a) (Type,	Print)	מינה	95) 1 <b>-</b> 0	7 X	overly	Tes	yeary !	16	100	)/
	Sta Regist		31. Date filed (Mor	2007	30.0	32. Regis	strar's Signa	ture	ay c				y		any	ديم		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 2007 Februar BABALOLA OLABANJI /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Regional Hospita Laurel Laure If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days Months 1 M 2□F Vrs 03-25-1946 NIGERIA WA Director 60 577-78-4076 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No PRINCE GEORGE BOWIE Completed by Funeral Director MD the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 14628 LONDON LANE 20715 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No BLACK Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE **PROFESSOR** 5+ Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 Is marked of ELIZABETH AKINYANDENUS ENOCH BABALOLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16304 EDDINGTON RD BOWIE, MD 20716 OLU AJAYE/SON-IN-LAW 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 02-17-2007 LANDOVER, MD HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between O set and Death 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause Immediate Ceuse (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month detached for in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Rnown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performe Hospital or Attending Physician: director, . Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 은 1 ☐ Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 2 No 1 ☐ Yes death. after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier cause of death (Item 23a) (Type, Print) 13635

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 16 2007

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 13, 2007 6:30 Goldie Pauline Beachy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Garrett Goodwill Mennonite Home Grantsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2XF 87 Yrs. April 1,1919 Director 216-38-1448 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or Items 23a or 28e-f show the Medical Examinations the notified at 1 ☐ Yes 2 No by Funeral Director Grantsville Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21536 215 Posey Row Rd. Pages 1 and 2 should be filed within 72 hours after death 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Clerk Retail-Grocery 6 ith and Mental Hygie 27 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Ellen Durst Benjamin Butler ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a item 27 i P.O. Box 191, Grantsville, MD 21536 Marvin E. Beachy/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 0 1 Burial 2 Cremation 3 Removal from State = 5 Department of Important; If any injury or Feb. 18,2007 Grantsville, MD Oak Grove Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Curdio Della monar Pnysician /Medical **Examiner** neumonice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Day Por Month Year 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by sign be 2 No 3 Probably 4 Unknown EUS 1 🗆 Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 Yes 1 Tyes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Voursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending 1 Natural s after dea. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D003423 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robin Bissell, M.D., 124 Miller St., Grantsville, MD 21536 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🧻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 234 Drown **Physician** tarola 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 □ F Months Days 6078 -50-Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at saltimore 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hyglene.
Is marked other than "natural", or items 23a or? 45/24 A by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 61□Yes 2□No White If Yes, Give Year or Dates: 1953-19 Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical,
once. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Controllà insulato Srad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KGOWY 850WY usman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brown baltion045 04 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State DVC 2/12/07 Bith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** W+8/ /Medical Due to (or as a consequence of) Examiner OY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed CVA 2 No Yes Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

AVITOI

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 32. Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

FEB

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06252 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Gregory L. Bredbenner February 13, 2007 **Physician**  $A^{M}$ 7:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5520 Belva Street Prince George's Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
Wonths Days Hours Min. Feb 5, 1952 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊠** M 2□ F 55 216-60-0713 Yrs Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 □XYes 2 □ No Maryland | Prince George's Lanham the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 5520 Belva Street 20706 USA Itema 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ŏ Specify: White þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filk timent of Heelth and Mental Hy tant: If Item 27 is marked oth Be John Bredbenner Evelyn Singleton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5520 Belva Street, Lanham MD 20706 Christine Bredbenner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ite
ony injury or oth 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Chesapeake Crematory 2/19/2007 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List unity one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic esophageal cancer disease or condition resulling in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home **\$EX**Residence 6 Other (Specify) 1 Yes 2X No this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours efter death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and hanner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of February 14, 2007 MD33109

Registrar

State

30. Name and actor

31. Date Med (Month, Day, Year)
FEB 15 2007

ss of person

Hwang, M.D.

3800 Reservoir Road, Washington DC 20007

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State	State of N	Maryland / Dep Ce	artment ertificate			-	jiene leg. No. 20	0.7	06253
			Registrar     Decedent's Name (First, Middle)	, Last)			0. 200		2. Date of Dea	th	U 1	3. Time of Death
	Physicia		Marv	Rose	Bov1e				February	14. 2007	Year	11:05 A M
No.	/Medic Examin		4a. Facility Name (If not institution			4b. City, To	own, or Loca	ation of Death		4c. County o	f Death	23.700 11
			1610 Thomas Road			Ft. W	ashingt	ton		Prince	Georg	e's
	Funeral		5. Social Security Number		Age (In yrs. last birthda 80 Yrs.	/) If Under 1 Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day			ce (State or Foreign
	Director		579-48-4366	1 □ M 2/525€	8U Yrs.				May 19,			Ireland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation	-				100	d. Inside City Limits
	/anyli f sho	ō		<b>a</b> :	Ft. Wa	shington	L					1 □ Yes 2√2 No
	the N 28a- notiffi	Tec	Maryland   Prince (	eorge's		10f. Zip C				l0g. Citizen of Wh	nat Countr	y?
	with 3a or	Funeral Director	1610 Thomas Road			2	0744			USA		
	ms 2	era	11. Marital Status	12. Was Decede	nt Ever in U.S.			ic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race	- Americar	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied Armed Force 1 Tyes 2 If Yes, Give Year or Date	XXV°	1 ☐ Yes 2x	_	exican, Puerto ec <i>ify:</i>	Hican, etc.)	Specify:	White, et	ite
21215-0036	2 hou atura cal E	eq	15. Decedent	's Education	16a. Dec	edent's Usual	Occupation		. 4	16b. Kind of Bus	iness/Indu	istry
75	hin 7% In "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4c	life	re kind of work DO NOT use	done during retired)	g most of work	ing			
21	d wit giene er tha	ĕ	12			Home	maker				Home	
	be file tal Hy d oth	Be (	17. Father's Name (First, Middle,	•			18. 1			Maiden Surname	)	
Уa	Men Men arke	မ	Andrew Dola	-				Bridge				
Maryland	d 2 sh thand 7 is m traum		19a. Informant's Name/Relationsi Patrick Joseph B						al Route Numbe shington,	r, City or Town, S Marvland	tate, Zip 0 2074	
	1 and Healt tem 2		20a. Method of Disposition	Syste / Habbark	20b. Place of Dis				Date	20c. Location - C		
υO	ages ent of it: If it		1 Aurial 2 □ Cremation 4 □ Donation 5 □ Other (S		Resurrect			02/19	/2007	Clinton	Mary	land
Baltimore,	artme ortan injur		21. Signature of Funeral Service	14					1			
ä	Depar Impor any ir		Jro. Ka	las A)	`	6160 Oxo	n Hill	Road Ox	on Hill,	las Funera Aryland	20745	: r.A.
	T E III		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each	sed the death. Do not e	nter the mode	of dying, su	ch as cardiac	or respiratory an	est,	] [	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	AL.	zheims	5					1	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):							
ь	LXdillilei	Į.	Sequentially list conditions,	b. Due to (or	as a consequence of):							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence or).						1	
	execu	xar	that initiated events resulting in death) Last	c Due to (or	as a consequence of):						-	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicall		d								
9		edi										
Box	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pre	nancv			23d. Date	,	
	w requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/Me	in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of death	☐ Other (spe				Mon	ın L	ay Year
P.0	requires that the een signed by the nould be detache	Ph	Part (I. Other significant condition	ons contributing to deat	h but not resulting in the	underlying cau	ise given in	Part I.	23e. Did to	bacco use contrit	oute to the	cause of death?
Records,	uires 1 sign	d b	Atheroscler	otic Ca	rajooasa	2 lar	dis	50050	1 U Y	es 2 No 3	B □ Probal	bly 4XXUnknown
8	w req beer shou	ete						<i>3</i> × 11 000	24a. Was a	an 24b. W	ere autons	sy findings available
Re	The law ate has b	Ę							autop perfoi	sy pr med? de	ior to comp ath?	pletion of cause of
tal	an: T tificat tor, pa		25. Was case referred to medical				26.	Place of Deat	1 Yes h (Check only o		Yes 2	No .
>	Physician: r this certific ral director,	To Be	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpat	ent 3 DOA	Othor:			ence 6 □Othei	(Specify)	
0	ig Ph ter th neral		27. Manner of Death 1 ☑Matural 5 ☐ Pendin	28a. Date of I	Injury 28b. Time Day Year) Injur	of 28	c. Injury at Work?			ow injury occurre		
Θ	Attending r death. ector: After	atio	2 ☐ Accident investig	gation		M	1 🗆 Yes	2 □ No				
Division or Vital	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Hornicide determ	inca   Zoe, Flace Of	injury - At home, farm, , etc. (Specify)	street, factory,	office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural i	Route Number,
	urs af urs af eral D		On Continue of CVD antiferior	Dhalalan Talbah	f - muu lunavuladaa - da	ath againmed a			and don't be the			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		ng Physician: To the be Examiner: On the basi and manner	is of examination and/or							
	To the within 2 To the Comple	Me	29b. Signature and title of certifie			29c.	License nun		:	29d. Date signed		
			1 (1/1n	200			5274	41		Februar	y 15,	2007
	1 110	1	30. Name and address of person	•								
1	- 6	1	Caroline Caine M	D 11701 Liv	ingston Road	t. Washi	ngton,	Marylan	1 20744			
	Sta Regist		31. Date filed (Month, Day, Year) FEB 15 2007	Signature 32. Reg	istrar's Signature	ブ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** Stefan Blesneac (NMN) 2007 2:08p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Institutes of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Oct. 9, 1 **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 1⊠M 2□F 209-72-8261 1954 Oct. Romania Director 52 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 21 No Director PA Lancaster Ephrata 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17522 325 West Main St. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à Specify: 3 Widowed 4 Divorced White Year or Dates: Completed er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Self Employed Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Vasily Blesneac Alexandrina unk item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 West Main St. Patrice Blesneac/Wife Ephrata, PA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-19-2007 Family Cemetery Bukerest, Romania 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th st. N.W. Washington, 21. Signature of Funeral Service Licenses 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PCP Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Aspergillous Pneumonia Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit VRE Bacteremia The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þe 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an page 2 autopsy 11 Yes Division or Vital 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of confilter 29c. License number 29d. Date signed (Month, Day, Year) IL-036111053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
National Institutes of Health 10 Center Dr. Bethesda, MD 20892 31. Date filed (Month, Day, Year \*32. Registrar's Signature State FEB 15 2007 Registrar

			1 = For Stata Registrar	State of Mar		artment of F		F	Reg. No.	07	06255
П	Physici	ian	Decedent's Name (First, Middle,					2. Date of Dea	Day	Year	3. Time of Death
	/Medi	cal	Oscar	Benso	n	At Ch. Tour	al and a st David	reorus	m/10,-	AO)	0916
	Examir	ner	4a. Facility Name (If not institution,	give street and number)	ne for	46. City, Town, o	r Location of Death		4c. County	y of Death	1-4-
	Euporol		5. Social Security Number	6. Sex 7. Age (	In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h SICI	9. Birth	polace (State or Foreign
	Funeral Director		222-16-8688	102M 2□F 75	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day 05-28-	(931	Dela	pplace (State or Foreign untry) aware
	P _		Usual Residence of Decedent					-			
	arytar ehow	2	10a. State 10b. County		0c. City, Town or L	ocation					10d. Inside City Limits 1
	Ba-f	ecto		hester	Can	nbridge					
	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28a-1 show the Maryland Exerting transities recitified at	Funeral Director	10e. Street and Number	+ A-+ 10		10f. Zip Code 2161	2		10g. Citizen of USA	What Col	untry?
	eath	erai	700 Race Stree	12. Was Decedent Ev	erin U.S. 13			pecify Yes or No-		ce - Amer	ican Indian,
10	r then	Fun	1 Never Married 2 Marrie	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	Rican, etc.)	Bia	ck, White	
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specia	<sup>fy:</sup> B1	ack
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest	s Education	16a. Dece	edent's Usual Occup	ation	kina	16b. Kind of B	Business/I	ndustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done DO NOT use retired	d)	9			
2	filed w Hygier other th		UNE		I	Processing		- (Final Mina)	Coast		ood
and	htal H	Be	17. Father's Name (First, Middle, L				18. Mother's Nan		Maiden Sumai	me)	
Ĕ	should Ind Men	2	Emanue 1  19a. Informant's Name/Relationsh	Benson	10h Mail	ing Address (Street	Sally		. City or Town	Ctata 7	in Codel
Maryland	d 2 sl th an t7 ie r traur		Delbert Benson			1 Hornspo					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, the Moultal Exaction or required at an once.		20a. Method of Disposition	, Brother	20b. Place of Disp	osition (Name of		Date	20c. Location		
<u>ا</u>	Pages nent of int: if it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.			matory or other place.  Chapel (		7-2007	Emandam:		Delerrane
Baltimore,	permit. F Depertme Importar eny Injur		21. Signature of Funeral Service L	**		2. Name and Addre	ss of Facility			rca,	Delaware
ñ	Depermination of the permitted of the pe		l'ammie	Shaw		Bennie Sn 524 Race	nith Fune E Street,	ral Home Cambrida	e Marv	1and	21613
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the	e death. Do not en						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	41	liducu dis	Chr					Onset and Death
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	cate be executed ohysician and the burial-transit	icai Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c							
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9 X	The law requires that the death certificate be executed sie has been signed by the attending physician and bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy				004.0	4- a4 d-15	
Вох	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2   4 ☐ Pregnant at tir	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	1			ite of deliventh	Day Year
P.O.	the d y the	isk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown							
	res that signed b be dete	y P	Part II. Other significent condition	s contributing to death but	not resulting in the o	underlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to	the cause of death?
rds	quire n sign uld be	p p	longestive hear	t tallusc				1□Y	es 2□No	3 ☐ Pro	bably 4 Unknown
of Vital Records,	aw requir as been si 2 should	Completed by	Dichetes					24a. Was a	an 24b.	Were aut	opsy findings available
æ	The lay te has	шо	Perinteral Vac	cular disca	00			autop:	med?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of 2 □ No
ital	ician: Th certificete rector, pag	0	25. Was case referred to medical	Cather off sta	- }-{		26. Place of Dea	1 ☐ Yes th (Check only or		105	2 140
f V	Physica this ce al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	05	ome 5 ☐ Resid		ner (Spec	ify)
0	fer th	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (	of 28c. Injur Wor	y at k?	28d. Describe h	ow injury occur	red	
Division	uttendii death. ctor: A y the fu	Certification:	2 Accident investiga	ation			Yes 2 □No				
Ž	ter diffect	ı	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		- At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Numt n, State)	ber or Rui	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		20 2 47								
	Hosi 24 ho Fund tely fi	Medical	29a. Certifier 1 Certifying (Check bril) 2 Medical E	Physician: To the best of a xaminer: On the basis of each manner state	camination and/or in	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, c	ause(s) and mate and place,	anner as : and due :	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and tyle of certifier		u.	29c. Licens	e number	2	29d. Date signe	ed (Month	, Day, Year)
	⊢₃⊢ŏ		) ( Wh	M.D.			65064		2-10-		
			30. Name and address of person w	ho completed cause of dea	th (Item 23a) (Type						1
	(3)		DAVIDADA TA	ILALL, MO	507	BYRN ST	CAMB	RIPLE ,	MD 21	1613	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Low					

	•		artment of Health and Mental F	
Physicia /Medica	_	1. Decedent's Name (First, Middle, Last)  Robert Dwight Bohaker	2. Date of Month Febru	Death 3. Time of Death
Examine Funeral Director		4a. Facility Name (If not institution, give street and number)  William Hill Manor  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4b. City, Town, or Location of Death  Easton  If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March	4c. County of Death  Talbot  Birth Day, Year)  30, 1917 Massachusett
in the Maryland or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or town  MD Dorchester 10c. City, Town or town ore		10d. Inside City Limi 1 ☐ Yes 2 ☑ N
th with the 23a or 28 set by nat	Funeral Director	10e. Street and Number 5444 Tates Bank Road	10f. Zip Code 21613	10g. Citizen of What Country? USA
S S I	۾	11. Marital Status  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2₺ No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White
ad within 72 hours afl giene. er than "naturel", or the Wolcel Ex	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  11  15a. Decedent's Education (Giv   Giv   Iiife.)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) minister	episcopal church
d 2 should be filed the and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) Timothy Dwight Bohaker	18. Mother's Name (First, Middle Lulu Mae Ga	rdner
1 and 2 st Health and 8m 27 lar		Timothy D. Bohaker son 5444	1 Tates Bank Road, Cambr	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm M.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ry Crematory 2/13/07	Salisbury, MD Funeral Home P.A.
sician and /Medical Examiner  Sician and purial-transit	al Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enshow, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or respiratory  Lem Cerebrungelen Acci  rcula Pakace	Interval Between Onset and Death
Attending Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Medic		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
quires that n signed build be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death? ☑ Yes 2 ☑ No 3 ☑ Probably 4 ☑Unkno
sician: The law re- certificate has bee rector, page 2 sho	Completed	Stone IV July when 2° GI Glood Stone IV July when of a	tacum 1□ Yes	topsy prior to completion of cause of death?  2 No 1 Yes 2 No
To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funaral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification: To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at Work?  M 1 Yes 2 No	e how injury occurred
		4 Homicide determined 286. Place of injury. At nome, farm, s building, etc. (Specify)  298. Certifier 1 Certifying Physician: To the best of my knowledge, dea	City or the control of the control o	(Street and Number or Rural Route Number, Fown, State)  ne cause(s) and manner as stated.
To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	Medical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or i and manner stated.  29b. Signature and title of certifier  WILLIAM HUMM	nvestigation, in my opinion, death occurred at the time 29c. License number	e, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
State		30. Name and address of person who completed cause of death (Item 23a) (Type William H. Wood Jr. M.D. 28474 F	(ings Wood Dr., Easton, I	MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** Bel1 Roy 11 AM  $^{\rm M}$ 11,2007 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Odenton 526 Patricia Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Days 144-01-9018 Director May 29,1922 NJ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, th⊾ Medical Examiner must be notified at 1 ☐ Yes 2 No Director Odenton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 Patricia Court 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 √Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1952-Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Officer US Army Alth and Mental Hv. 7 is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grossman Sadie Belafsky Hayman ပ္ 19a. Informant's Name/Relationship *(Type.* Dorothy Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a:
Important: if item 27 is
any injury or other trau 526 Patricia Court Odenton, MD 21113 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans 20c. Location - City or Town, State Crownsville Feb. 16,07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home P.A. 851 Annapolis Road
Gambrills, MB 21054 21. Signature of Funeral Service Licensee Salut Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician the Prostak metastatic Hdenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 \ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this certificate.

29b. Signature and title of certifier

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MD 21231 ichael A. Carducci MD 401 North Broadway. 31. Date filed (Month, Day, Year)

State Registrar

FEB 13 ZUU



Medical

29a. Certifier

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otato of maryic		tificate of		, ,	g. No. 2	7 06258
	Physici	an	1. Decedent's Name (First, Middle, Last Calvin M. Blake,					2. Date of Death Month	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of Death	1	4c. County of Dea	
4	Examil	lei	PININSULA REGIONAL	Medica Cel	rter	540	436411		NICOM	
	Funeral		5. Social Security Number 6. Se	YM 2DF	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) C	rthplace (State or Foreign ountry)
Δ	Director		214–36–5834 Usual Residence of Decedent	68	713.			Oct 13,	1938	MD
	ıryland show	-	10a. State 10b. County		City, Town or Loc	cation				10d. Inside City Limits
	he Ma 28a-f s	Director	MD Wicomico	S	alisbury			1.10		1XYes 2 No
	with t	ij	10e. Street and Number	mal a		10f. Zip Code		10	g. Citizen of What C	ountry?
	death	Funeral	815 Springfield Ci 11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	21804 Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Am	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes 212 No	Specify:	Hican, etc.)	Black, Wh	· _
15-0	יין 72 ה "natu edical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give I	ent's Usual Occup kind of work done of OO NOT use retired	durina most of work	ing 1	6b. Kind of Business	s/Industry
212	withir iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	1		" tion Offi	cer	Law Enfo	rcomont
br	e filed al Hyg other vent, i	Be C	17. Father's Name (First, Middle, Last)	······································		dobilica		e (First, Middle, Mi		realere
ylar	should be filed wand Mental Hygies smarked other tumatic event, th	To E	Charles W. Blake,				Margaret			
Maryland	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (T) Sandra D. Blake/wi		I				City or Town, State,	
	is 1 and 2 of Health item 27 i		20a. Method of Disposition			opt Inglie sition (Name of natory or other place			ury, MD 2	
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	t. Wesle	y United Church Name and Addre	2/16	7/2007	Snow Hill	MD
3alti	permit. Pag Department Important: I any Injury o once.		21. Signature of Eunéral Service Licens	ee , jvj	22.	Name and Addre	ss of Facility atson Fun			, 1.115
	□ □ = # O		23a. Part1. Enter the disease, or compl	LSOTA	16	18 West	Rd. Sali	sbury. M	21801	A
	Physician		shock, or heart failure. List only o	ne cause on each line.	•	i the mode of dyir	ig, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):					
	Examiner		Sequentially list conditions.	). H	yperte	ncico				
	ted sit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	e fuence of):	01 10 1				
,	execut n and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):	(Macmir	<u> </u>			
68760,	rtificate be executed ng physician and as the burial-transit			it						
	ertifica ing ph e as th	Medical	IF FEMALE:							
P.O. Box	The law requires that the death cer tre has been signed by the attendir rage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)	<u> </u>		23d. Date of de Month	elivery Day Year
	res that igned b	by Pi	Part II. Other significant conditions co	ntributing to death but not r	esulting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ord	w requir been si should b							1 ☐ Yes	2 No 3 P	robably 4 Unknown
or Vital Records,	e law has b	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
talF			25. Was case referred to medical						death? No 1 ☐ Yes	s 2 No
N N	ysician: is certific director,	o Be	examiner?	lospital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DOA Othe	or.	n <i>(Check only one)</i> me 5 ☐ Besiden	ce 6 □Other (Spe	noiful
n 0	Attending Physician: r death. ector: After this certific by the funeral director,	Ju: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun		28d. Describe how		эспу)
Sio	Attendla death. ctor: A y the fu	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
Division	after death Director:	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License			I. Date signed (Moni	th, Day, Year)
	700		· X Uf			Hus	56157		2/12/200	>
1	100		30. Name, and address of person who co	impleted cause of death (It	em 23a) (Type, P	Print)	Jaliba		21841	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	3	- 1320			
	Registr	ar	FEB 1 4 20	107 /	K A	and s				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Maryland / Dep	partment of Health and Nertificate of Death		ene () () 7	06259	
1	16 % at		Decedent's Name (First, Middle, Last)		2. Date of Death	g. 140.	3. Time of Death	
*	Physici		Lottie Virginia Benedict		Month February	Day Year 21, 2007	01104 M	
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	rebraary	4c. County of Dea	0113A ***	
			Coffman Nursing Home	Hagerstown		Washingt	on	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Date of Birth 9. Birthplace (State or		
	Director		220-54-2657 1 M 2 F 93 Yrs.	Months Days Hours Min.	May 15 1		ountry) t Virginia	
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	agation			10d. Inside City Limits	
	sho	2					1 XYes 2 □ No	
	28a-1	Director	Maryland Washington 1857 Mer	idian Drive Hager:		g. Citizen of What C		
	with	ក្			100		ountry?	
	eath	era	1857 Meridian Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13	21742 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A.	erican Indian	
·0	fler o	Funerai	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi		
ဗ္ဗ	urs a	by	3 Ma Widowed 4 □ Divorced	1 ☐ Yes 2 No Specify:		Specify: Wh	ite	
21215-0036	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	16	6b. Kind of Business		
21	thin 1	pie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	iiig			
2	ed wi	Con	12 Homer	naker		Domestic		
밀	tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)		
<u>≯</u> a	Men	2	Jesse James Drake		Leona Mi			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exeminant Landilland at once.			ing Address (Street and Number or Rur				
a)	and iealth im 27		Virginia Kay Carbaugh / Daughter 185	Meridian Drive Ha				
ō	If Its		1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, cri	ematory or other place)		Oc. Location - City or	Town, State	
Ë	t. Pa rtmer rtant			g Crematory   2/25			Maryland	
a Ba	Depending Indo			22. Name and Address of FacilityRes				
	45240			1601 Pennsylvania				
			23a. Part1. Enter the disease, or complications that caused the death. Do not es shock, or heart failure. List only one cause on each line.		or respiratory arres	ī,	Approximate Interval Between Onset and Death	
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	n CAncer			6 m	
	Examiner		Due to (or as a consequence of):	·				
		-a	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
1	uted s nnsit	m in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, Disease or injury					
, 	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last c					
8760,	sate be executed hysician and the burial-transit	dicat						
9	tificate ng physi as the t	ledi						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of de	livery	
	death he att	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year	
P.O.	that the de led by the a detached f	Phy	9 Unknown					
	8 50	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?	
or o	w require been si should b	ted			1  Yes	2 □ No 3 □ Pi	robably 4 Unknown	
Records,	has b	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
	The	Co			performe 1  Yes 2  €	ed? death? XNo 1 ☐ Yes		
/ita	cian	Be	25. Was case referred to medical examiner?		n (Check only one)			
5	Physician: The la r this certificate has ral director, page 2	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 □Other (Spe	cify)	
Division of Vital	ling F After uner	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred		
S	Attending in death.	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	296 Landing (Ct.)			
<u>&gt;</u>	or A after Direction by	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	City or Town,	et and Number or Ri State)	ural Route Number,	
_	pital ours ours filled		29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cour			
	Hos 24 h Fur etely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or i one)	restigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)	
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Mont	h, Dey, Year)	
	, ,, ,			D52323	0	2-21-	2007	
	2		30. Name and address of person who completed cause of death (Item 23a) (Type				•	
	0				ma 2	1740		
E.	y	te	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	Court HAS.	<u> </u>			
	Registr	ar	MAR 1 2007 Beau &	Goode				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 23 2007 11:22p **Physician** JOAN BARTLEY BOOZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Wing - Heron Point Chestertown Kent 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 4 1925 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 311-20-5728 1 M 2 TF Indiana Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director MD Kent Chestertown 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21620 U.S.A. 120 Heron Point or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Iten any injury or other treumetic event, the Wedfold Examenance. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle L. Hadley 17. Father's Name (First, Middle, Last) Be Donald A. Bartley ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chestertown, MD.21620 120 Heron Point Charles S. Booz, Jr. (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Kent Cremation 2/25/07 Smyrna, DE. • 4 □ Donation 5 □ Other (Specify) 21. Signatura Maneral Service Linnsee 22. Name and Address of Facility Galena Funeral 118 West Cross Home of Stephen St. Galena, MD. L. Schaech 21636 M00510 Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cayse (Finat PNEUMONIA 3 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 981 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part (I. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed Completed by ALZHEIMERS DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 No to the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours after To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number D0041587 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2-24-2007 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

	Certificate of Death	R	eg. No.	
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deet Month	Day Ye	
/Medical	Elegior 0. Earle	Feb. 21		7:35 p.
Examiner			4c. County of D	
	421 Hammond Street Westerng  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Allega	ΠΥ Birthplace <i>(State or Fore</i>
Funeral	1 M 2 F Yrs Months Days Hours Min.	(Month, Day,		Country)
Director	220-32-4993 71 Usuel Residence of Decedent	12/16/	/ 55	MD
Hygiene. ther than "natural", or items 23a or 28e-f show ont, the Medical Examinet must be notified at a Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lir
to rot	MD Allegany Westernport			1- Yes 2□
or 28	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?
23a 23a 3a 3a 3a 3a 3a 3a 3a 3a 3a 3a 3a 3a 3	421 Hammond Street 21562		U.S.A.	
nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton Puert	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. hite
ygiene.  In the Medical Exart, the Medical Exart  Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	cina	16b. Kind of Busine	ess/Industry
an "r	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)			
Hygiene. other than ent, the M	1 Hairdresser	- (5) -4 441441- 1	Persona	1. Care
d oth	17. Father's Name (First, Middle, Last)	. Smithe	Maiden Sumame)	
Mental Merital of Marked o	nairy w. Evalis		-	to Zio Codo)
salth and Mening 127 is marked or traumatic	19a. Informant's Name/Relationship (Type, Print)  Rebecca Meinhardt/daughter  15001 Baden Naylor			
Health em 27 rther tr	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City	
nent of I int: If ite ury or o	1 Burial 2 SCremation 3 Hemoval from State	2/22/07	Oregonto	. MD
Depertment of important: If any injury or once.	4 □ Donation 5 □ Other (Specify) Scarpelli Crematory 2  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	122/01	Cresapto	W.CI, MJD
Depertmentary any injure price.	Markwood Funeral H			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	_26726 est.	Approximate Interval Between
hysician /Medical ixaminer	Immediate Cause (Final disease or condition resulting in death)  a. Ended Color Can Due to (6r as a consequence of):	al		Onset and Death
been signed by the attending physician and should be detached for use es the bunat-transit letted by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
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nis certificate hes la director, pege 2 s		1 🗆 Y	es 2½ No	1 ☐ Yes 2 ☐ No
ector.	25. Was case referred to medical examiner?	th (Check only or		
After this certific funerel director.	1 Yes 22 No 1 inpatient 2 EN/Outpatient 3 DOA 4 Nursing H	- '	ence 6 Other (Sow injury occurred	Specify)
within 24 hours effer deeth.  To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To Medical Certification: To	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town		or Rural Route Number,
n 24 hours ne Funeral pletely filled	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred et the time, d	late and place, and	due to the cause(s)
within 2 To the comple	29b. Signature and title of certified	01 2	29d. Date signed (M	fonth, Day, Year)
	1/1/0gonerm 1/22k	J/F	ed Rumy	122200
2	30. Name and address of person who completed cause of death (flem 23e) (Type, Print)		0	
<b>♂</b>	Gary L. Wagoner, 925 Bishop Wash Dr., Cumberland, MD 2	21502		
	31. Date filed (Month, Day, Year) 32. Hegistrer's Signature			

DHMH 16 Rev 6/95

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after deau...

To the Funeral Director: Af

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 15 2007

Brian

29c. License number

D0064502

9901 Medical Center Dr. Rockville Mrs 20850

29d. Date signed (Month, Day, Year)

2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

CARPONTER

MD

32. Registrar's Signatur

_			1 - For State Registrar	State of M	laryland / Dep		lealth and I			7 06263		
	Physic	ian	Decedent's Name (First, Middle, Last     On THE TEXT					2. Date of Death Month	Day Ye	3. Time of Death		
	/Medi	cal	CATHERINE		-1	45 C2 T		02	13 200	07 7:40 P <sup>M</sup>		
	Examir	ner	4a. Facility Name (If not institution, give HARFORD MEMORIAI				r Location of Death		4c. County of Death			
	Funeral		5. Social Security Number 6. Se	7. A	ىك ge (In yrs. last birthday)	If Under 1 Year	DE GRACE ff Under 24 Hrs.	8 Date of Birth	HARFO	ORD Birthplace (State or Foreign		
	Director		218-32-9598	]M 2[ <b>X</b> F	71 Yrs.	Months Days	Hours Min.	MAR 13,	1935	VIRGINIA		
_	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				1404.1		
	Marylan fed at	Ď	MARYLAND HARFOR	טו <i>ר</i>						10d. Inside City Limits 1 X Yes 2 □ No		
2	with the Marylar a or 28e-f show the natified at	Director	10e. Street and Number	Ψ		ABERDEEN 10f. Zip Code		100	. Citizen of What			
34	23a o	ai D	20B E. BELAIR AV	ENUE. AP	ጥ 14	210	<u> </u>		USA	out.		
_	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces		Was Decedent of H		pecify Yes or No-		merican Indian,		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 ff Yes, Give	No	1 ☐ Yes 2 X No	Specify:	ornoun, oto.,	Sanaifu			
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show 'in Madical Examiner must be notified.	edt	15. Decedent's Edu	Year or Dates:		dent's Usual Occup	ation	100		BLACK		
215	hin 72	piet	(Specify only highest grad Elementary/Secondary (0-12)	completed) Colfege (1-4or	(Give	kind of work done of DO NOT use retired	during most of work	king	b. Kind of Busine	ss/industry		
212	filed wit Hyglene ther th	Completed	5	College (1-40)	34)	DOMEST	[C	:	PRIVATE	HOMES		
) pu	o d al	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)			
New Y	d 2 should be th and Mental t7 is marked c fraumatic ave	2	UNKNOWN				FRANCES					
Ma <sub>l</sub>	d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (Ty  CATHERINE PRITCHET					ral Route Number, C				
ୁ ହି	s t and f Health item 27 other tr		20a. Method of Disposition	I / DAUG	20b. Place of Dispo	sition (Name of		VER, DELA	WARE 199 c. Location - City			
Baltimore			1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	UNION UNI	natory or other plac	1			, MARYLAND		
a II	pernit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License	90	1000	2. Name and Addres	ss of Facility			MAKILAND		
	88558		John Scot	t-Colo	me	- ううと しばん	ITS STREET	RAL HOME, T, HAVRE I	P.A.	_ MD 21078		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause le cause on each !	#1 <del>0</del> .	er the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)		DISSEMIN	MED IN	Travascul	w COMAUI	MINON	Onset and Death		
$\mathcal{L}_{\mathfrak{J}}$	/Medical Examiner		resulting an death)	Due to (or as	a consequence of):	- 1	/m. 1.	w Congul icen	7,70			
18.4		er	Sequentially list conditions, if any, leading to immediate	. Due to (or as	a consequence of):	Tic Col	m (AN	cen		6 MONTHS		
	cuted	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
,0	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):							
, 8760,	physic physic s the bi	dicai										
×6	eath certificate attending phys for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy							
S	atter for u	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year		
0	that the ded by the detached	hysi	9 Unknown	9□ Unknown		TOTHER (Specify)						
~ °,	res that igned to be det	by P	Part II. Other significant conditions con	tributing to death b	out not resulting in the ur	nderlying cause give	in in Part I.	23e. Did tobace	co use contribute	to the cause of death?		
ord	w requires been sign should be							1 TYes	2 No 3	Probably 4 Unknown		
)	law as b 2 sl	Completed						24a. Was an autopsy	24b. Were	autopsy findings available		
OF.	ding Physician: The h. After this certificate hi funeral director, page	Con						performed	No 1 ☐ Ye	completion of cause of		
Sita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Lou		Check only one				
2.0	Phys r this aral dii	<u>۲</u>	1 Yes 2 No	1 ☐ Inpatie		3 DOA Othe	4 Livursing Ho	me 5 Residence		pecify)		
<u>o</u>	ttanding I death. stor: After the funer	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	Work	? 'es 2 □ No	28d. Describe how in	fury occurred			
Nis.	r Attand er death rector: , by the f	Hick	3 Suicide 6 Could not be determined	28e. Place of fn	ury - At home, farm, stre			28f. Location (Street	and Number or I	Rural Route Number,		
~ <<	rs after or an Direction	Certification:	Tiomede	building, et	c. (Specify)			City or Town, St	ate)			
		Medical	29a. Certifier (Check only one) 1 Certifying Phys	cian: To the best er: On the basis of and manner sta	of my knowledge, death f examination and/or inv ated.	occurred at the time estigation, in my opi	e, date and place, inion, death occurr	and due to the cause ed at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)		
	4540	9										
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c, License	number	29d.	Date signed (Mor	nth, Day, Year)		
	To th within To th compl	Me	> Meller			DUI	097.2		Date signed (Mor	nth, Day, Year)		
•	To the within To the comple	Me	29b. Signature and title of certifier  30. Name and address of person who con	npleted/cause of d	leath (Item 23a) Typer F	DUI	097.2		Date signed (Mor	njh, Day, Year)		
•	1).		> Meller	AN 4	leath (Item 23a) Gyper F	DUI	number 0922 We HA		Date signed (Mor 2/14/-	nih, Day, Year)		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1055 M **Physician** 200 DOLORES SATTERFIELD CHANCE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT ASTON HOSPITAL MEMBRIAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOVEMBER 2,1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. MARYLAND Director 220-28-2467 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ir then "natural", or items 23a or 28a-f ehow Its Medical Executives must be obtilised at 1 ☐ Yes 2 No Director MARYLAND | QUEEN ANNE'S QUEENSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21658 USA 7304 MAIN STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry STATE OF Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 12 MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi lealth and Mental H em 27 is marked ot JAMES HENRY SATTERFIELD ALICE MABLE THOMPSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any injury or other trau WILLIAM FORD CHANCE/HUSBAND 7304 MAIN STREET, QUEENSTOWN, MARYLAND 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 2007 21. Signature Funeral Service Licensee FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, an each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 nknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 21240 1 ☐ Yes 1 ☐ Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 2 3□ DOA To the Hospital or Attending Physical 24 hours effer death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anathan Lakshmu Varely DO 57749 FEBRUARY 13 2007 10 5h 30. Name and address of person who com ted cause of death (Item 23a) (Type, Print) LAKSHMIC VAIDYANATHA 219 SOUTH WASHINGTON STREET, EASTON, MARYLAND 21601 31. Date filed (Month, Day, Year) 32. R of trar's Signature State 2007 Registrar

		State of Maryland / Dep		•	•	70 F-75		
		- FOI	rtificate of Death	Reg. N	711117	06265		
		Decedent's Name (First, Middle, Last)		2. Date of Death	ay Year	3. Time of Death		
Physic /Medi		Donald Duncan Cameron		February	12 2007	9:35 a. <sup>M</sup>		
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death			
	Ш	5253 Stone Boundary Road	Cambridge  If Under 1 Year If Under 24 Hrs.	9. Date of Birth	Dorchester			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 2 F 87 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year		ace (State or Foreign (ry)		
Director		Usual Residence of Decedent		May 7, 1	919 New	York		
ryland		10a. State 10b. County 10c. City, Town or L			10	Od. Inside City Limits		
Ba-f	Director	MD Dorchester	Cambridge			1 ☐ Yes 2 🛣 No		
it die	Pie Pie	10e. Street and Number	10f. Zip Code		itizen of What Count	try?		
eath v	Funeral	5253 Stone Boundary Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21613 Was Decedent of Hispanic Origin? (Sp		USA 14. Race - America	an Indian,		
fler d	Fu	1 ☐ Never Married 22 Married 1 23 Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Sp tf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e			
Durs a	Ď	3 ☐ Widowed 4 ☐ Divorced tt Yes, Give Year or Dates: WWII	1 ☐ Yes 2 ☑ No Specify:		Specify: W.h.:	ite		
72 hc	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Ind	lustry		
within 100.	Completed	Etementary/Secondary (0-12) College (1-4or 5+)	truck driver		ransportat	tion		
Hygie hat,		10 17. Father's Name ( <i>First, Middle, Last</i> )		e (First, Middle, Maide		21011		
id be entai	To Be	Byron Ames Cameron	Lucie C	hadwick				
Lail y lattice Z I Z I J J J J J J J J J J J J J J J J	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rur	al Route Number, City	or Town, State, Zip	Code)		
and 2 aulth a n 27 i		Mary Cameron wife 525	3 Stone Boundary R	d., Cambri	dge, MO 2	21613		
S S S S S S S S S S S S S S S S S S S		1x3Burial 2 Cremation 3 Memoval from State	ematory or other place)	Date 20c.	Location - City or To	wn, State		
Deficiency Pages Separation of mportant: If it in my injury or once.					rlock, MD			
perillicie, individual VIZIO COO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once.			22. Name and Address of Facility $ $	homas Fune mbridge. M		2.A.		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	<u> </u>		21013	Approximate		
Physician		Immediate Cause (Final				Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death)  a. metastatic properties of the properties	state cancer			months		
Examiner		Sequentially list conditions D						
ם ב	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
executed executed on and ial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		_				
	E E							
EOX OO/ leath certificate attending phys		d.			T			
ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delive			
	sicla	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5	Other (specify)		Month	Day Year		
requires that the de neen signed by the a	Phy	9 L Unknown	ad a bita a superior David	23a Did tabaaa	use contribute to th	a squar of death?		
res th	<u>ج</u>	Part II. Other significant conditions contributing to death but not resulting in the progressive dementia	underlying cause given in Part I.		2XINo 3 ☐ Prob			
law requires I as been signe	eted			-				
VICAL MEC sician: The law s certificate has b lirector, page 2 sl	Completed	old CVA		24a. Was an autopsy performed?	death?	osy findings available npletion of cause of		
VICAL TA ICIAN: The Certificate h ector, page	ပို	CHF 25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 🛣 N h (Check only one)	lo 1 🗆 Yes	2 No		
ysicia ysicia is cert direct	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	ome 51X Residence	6 ☐Other (Specify	)		
ng Phy ng Phy ter this neral d	Ju: T	27. Manner of Death tX□Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how in	ury occurred			
SIOI eath. or: A	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No					
or Attending after death.  Director: After in by the function	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rurai ite)	I Route Number,		
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1\(\sum_{\text{C}}\) Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the cause	(s) and manner as st	ated.		
• Hos 24 h	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date a	nd place, and due to	the cause(s)		
To th within To th	Me	29b. Signature and title of continer	29c. License number	29d. E	ate signed (Month, L	Day, Year)		
		> 2/ >1/47919AN	D58662		2/14/07			
		30. Name and address of person who completed cause of death (Item 23a) (Type						
		Encarnita I. Santos-Tecson M.D.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	830 Chesapeake Dr.	, Cambridg	re, MD 216	13		
S Regis	tate trar	FEB 1 2007	And a					

		,	For State Registrar	State of Marylar		nent of He			iene 0 0 7	06266
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
Н	Physici		Marie	Copper	Curtis	<b>S</b>		February	Day Year	In a - A M
1	/Medio Examin		4a. Facility Name (If not institution, give s				Location of Deat	1 COPURA	4c. County of Dea	
	Exami		Easton Memono	1 Hospital	(	Eastor	)		Talbot	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
	Director		220-03-5332 10	M 2007F	2 Yrs. Moi	nths Days	Hours Min.	March 1	6,1914 M	aryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Location				/	10d. Inside City Limits
	aryla shov	٦								1 Tyes 2 No
Y	28a-f	ect	MD Dorch  10e. Street and Number	ester	Hurlo	f. Zip Code			Og. Citizen of What C	
7	with	古	11.	al D	1	216	1/2		ig. Citizen of What C	ountry?
3	eath	Funeral Director		12. Was Decedent Ever in U	IS 13 Was I	04,0	, _	necty Yes or No-	14. Race - Am	erican Indian
0	iten iten	Ë	1 ☐ Never Married 2 ☐ Marned	Armed Forces? 1 ☐ Yes 2 ☑ No		_	, Mexican, Puert	pecity Yes or No- o Rican, etc.)	Black, Wh	
ğ	hours after death with the Maryland turel', or Items 23e or 28e-1 show at Exeminer must be notified at	۵	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 21 No	Specify:		Specify: 6/	ack
5-0036	"natural", or	Completed	15. Decedent's Educ		16a. Decedent's	Usual Occupa	tion uring most of wo	tina	16b. Kind of Busines	
2	within 72 ene. then "net he Medic	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)				
2	ed wi	ပ္ပ	1/		Child					Ise's home
D	t be filed within 72 ho ntal Hygiene. ed other than "natur : event, the Medical	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
<u> </u>		은	UNKNOWN					e Jac		
Maryland	s 1 end 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)		. 2			. 11	City or Town, State,	
	1 end 1ealti sm 27		Dridget H. 20a. Method of Disposition	olland	4355- Place of Disposition		LA KODO	Date	K, Nary la	wd 216 43
و	00		1 1 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, crematory	or other place			ter.	
Baltimore,	pernit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		· Stephens	on and Addron				naryland
Ba	permit. Departm Importa any nju		Janelle C.	- Henry?	Hen	RY Fu	Wercel /	tome, P. A	bridge, N	001/12
			23a. Part. Enter the disease, or compli	cations that caused the dea	th. Do not enter the	mode of dying	inic tow	or respiratory arre	bridge, IV	Approximate
	Discordation.		shock, or heart failure. List only on Immediate Cause (Final	A trial	C-h .: 11	a time				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	JUY III	- CUOV				Vays
ı	Examiner			Myocaro		Parc +	Ton			D
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due lo (or as a consec		,	<del>-</del>			
	cuted	Examiner	that initiated events C							
Ö,	e exe ien a urial-1	Ä	resulting in death) Last	Oue to (or as a consec	quence of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal								
9	eath certific attending p	Me	IF FEMALE:	3c. If yes, outcome of pregn						
Box	attend attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta	al death 3 □Ecto	pic pregnancy			23d. Date of de Month	Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of o	Jean 5 One	er (specify)				
٥.	res that igned by be deta	F.	Part II. Other significant conditions con	tributing to death but not re-	sulting in the underly	ing cause give	n in Part I.	23e. Did tob	acco use contribute	o the cause of death?
<del>d</del> s	puires n sign aid be	d by	Memia					1 □ Ye	s 2 No 3 P	robably 4 Whown
ဝ္ပ	w require been sign should b	ete	Renal Leily	re				24a. Was a	24b. Were a	utopsy findings available
æ	Physicien: The lav this certificate has ral director, page 2	Completed	Dementia					autops perfora 1 ☐ Yes 2	prior to ned? death?	utopsy findings available completion of cause of
ta	un: tifica tor. p	BeC	25. Was case referred to medical		····		26 Place of Dea	1 ☐ Yes 2		s 2004No
=	ysici is cer direc	TO B	examiner? 1 Yes 2 No	ospital: 1 Unpatient 2	ER/Outpatient 3[	DOA Other	r		nce 6 ☐Other (Sp	ecify)
Ö	ng Ph ter th neral		27. Manner of Veath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho		
Ö	andin ath. or: Af	atlo	1 Natural 5 Pending 2 Accident investigation	(//////////////////////////////////////	M		es 2 □ No			
Division of Vital Records,	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fa	actory, office		28f. Location (Str City or Town	eet and Number or F , State)	lural Route Number,
	urs af urs af uref D									
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sicien: To the best of my knoter: On the basis of examinating	owledge, death occu ation and/or investig	urred at the time ation, in my opi	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	o the ithin ( o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	⊢s⊢ŏ		L'andreas H	han Mī		DO	577		)	9 200 7
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type Print)			411	C10. 154  N/	1 200 /
			Lakshmi Vaidyanath		South Wasl	ninata-	C+ D	ota- MD	21601	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign.	ature		OL. H	iston, m		
a	Registi	ar	FEB 1 % 2	UUI PRESENCE	His Allen					

			1 10430	State of Maryla				Mental Hygier	•	
			1 = For State Registrar	Oldie of Mary		tificate of			711111	06267
			Decedent's Name (First, Middle, Las	)	0		504111	Reg. I	<b>VO</b> .	3. Time of Death
	Physici /Medio		Annie	Mae	Ca	MPer		Feb.	1, 200'7	6:00AM
	Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death		c: County of Death	
			Mallard Bay	· Care C	enter	Ca	Mbric	1ge	Dorch	ester
	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. Birth	place (State or Foreign intry)
	Director		2 19-07-7970 10 Usual Residence of Decedent		12 Yrs.			Aug. 3,	1914 M	aryland
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
7	Many	tor	MD Darel	nester	12000	bisi de	) P.			1 1 Yes 2 □ No
5	r 28a	Funeral Director	10e. Street and Number	TC SIC!	Can	10f. Zip Code	1	10g. (	Citizen of What Cou	intry?
ξ	23a o	aiD	520 Glen	burn Av	enur.	21	613		USA	
2	ems Fr	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White	
36	or it		1 Never Married 2 Married	1 ⊟Yes 2 <b>⊒Y</b> Ño If Yes, Give		☐ Yes 2 No	Specify:	7 110411, 0101,	Specify: A	
5-0036	iiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-1 show that the Medical Examinar must be notified at	Completed by	3  Widowed 4  Divorced	Year or Dates:	100 Barre				D1	ack
က်	in 72 n" r	olete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	ent's Usual Occup kind of work done of OO NOT use retired	during most of wor	king 16b.	Kind of Business/I	ndustry
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	.0			rker Ca	into las T	nduction.
ַ	Hygi other	BeC	17. Father's Name (First, Middle, Last)		11000	July 7	18. Mother's Nan	ne (First, Middle, Maid	en Sumame)	naus Irg
Maryland	Aental Aental rked o	To B	Fred	Jackson	$\circ$		Sa	rah P	autan	
ar	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, Tre Madical Examinar must be notified at		19a. Informant's Name/Relationship (T)			g Address (Street	and Number or Ru	ral Route Number, City	or fown, State, Zi	p Code) 29129
	5 € Z ±		Kimberly Do	nise Moo		5- F-OX	trot D	rive Colu	Mhia Sou	th Carolina
Baltimore,	ges 1 ar t of Hea if item or othe		20a. Method of Disposition / 1 12 Burial 2 Cremation 3 1		<ol> <li>Place of Dispos</li> </ol>	sition (Name of natory or other place	(e)		Location - C ty or T	own, State
Ē	nit. Pages artment of ortant: if it injury or o		4 □ Donation 5 □ Other (Specify)		Malon	e Cenet	Lery 2/	17/07 M	adison	Maryland
ga I	permit. Pag Department Important: any injury ence.		21. Signature of Funeral Service Licens	ee of D	22	Name and Addres	ss of Facility	Home, P. A		Management of the second
		_	Janelle	C'. Sten	ry 5	10 was	hingto	Home, P. A VSti Cam	bridge,	ND. 21613
			23a. Part1. Enfer the disease, or comp shock, or heart failure. List only o	ications that caused the do ne cause on each line.	eath. Po not ente	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	Ì	Immediate Cause (Final disease or condition resulting in death)	Advonced	Debr	11 tales	State			Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	,				
		7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	LA IN					575
	ted nsit	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events	<b>546</b> (6) (3) & 6 (6)	equence or).					
	be executed icien and burial-transit	xai	resulting in death) Last	Due to (or as a cons	sequence of):					
9	0 0 0	cal		1						
9	eath certificat ettending phy I for use as th		7							
ROX	andin use	N/C	23b. Was decedent pregnant	3c. If yes, outcome of pred				,	23d. Date of deliv	ery
	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
J.	at the de by the e	Physiclan/Med	9 Unknown							***
Ś	The law requires that the death certifica lie has been signed by the ettending ph page 2 should be deteched for use as th	by	Part II. Other significant conditions co	28		derlying cause give	en in Part I.			he cause of death?
0	w requir been si should	ted	1/4 perporus	Typordes	wo			1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
Hecords,	e taw has b	Completed by						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u>~</u>		Š,		.3				performed?	death?	
Vital	Physicien: The transfer this certificate har al director, page 2	Be	25. Was case referred to medical examiner?	lospital:		Othe		th (Check only one)		
ō	Phys r this ral dii	<u>۱</u>	1 ☐ Yes 2 <del>☐ No</del> 27. Manner of Death	1 ☐ Inpatient 2	ER/Outpatient	3L DOA	A KLINUTSING H	ome 5 Residence		(y)
0	ding P. After funera	tlon	1 → Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury Work	(? Yes 2 □ No	28d. Describe how in	ury occurred	
Division	I or Attendi after death. Director: A I in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - Al	t home, farm, stre		103 2   110	28f. Location (Street a	and Number or Run	al Route Number
S	after i Dire d in b	Certification:	4 Homicide	building, etc. (Spe	cify)	- 1, 120101), 011100		City or Town, Sta	te)	ar riodie riomber,
	Hospital or Attending Physicien: 4 hours after death. 44 hours after death. Funerel Director: fiely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge, death	occurred at the tim	ne, date and place,	and due to the cause(	s) and manner as s	tated.
	he Ho in 24 he Fu	edicai	(Check only 2 Medical Exami one)	ner: On the basis of exami and manner stated.	ination and/or inv	estigation, in my op	pinion, death occur	red at the time, date ar	nd place, and due to	o the cause(s)
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by th	Σ	29b. Signature and title of certifier	>		29c. License	number	29d. D	ate signed (Month,	Day, Year)
			1/1/steel	leen	7	1)20	1388	F	J13, 2	2007
			30. Name and address of person who co	empleted cause of death (II		Print)	11 /	100	7/1/1	
20			31. Date filed (Month, Day, Year)	32. Regirar's Sig	3020	OITINS	17001/00	x max	0164	_5
	Sta Registr		FEB 14	2007	1 18	food				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WALTER DANCY tehruary 2007 /Medical 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LANHAM PRINCE GEORGE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07-13-1920 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 132-14-6483 1<u>₩</u>M 2□F 86 NORTH CAROLINA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No MDPRINCE GEORGE LARGO Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 500 N. HARRY S. TRUMAN DR #411 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature" any Injury or other trans. 1 Never Married 2 Married 1 ☐ Yes 2 No BLACK þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE BARRELL PROCESSOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE DANCY AMY WHITAKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRIE DANCY/WIFE 500 N. HARRY S. TRUMAN DR. #411 LARGO, MD 207774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN MEMORIAL 02-17-2007 |SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 7474 LANDOVER RD LANDOVER, MD 21. Signature of Funeral Service Licensee JB JENKINS FUNERAL HOME 20785 D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PHEUNONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STRIAL FIBRILL ATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Mknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was ar autopsy performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death
1. ☐ Natural
2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESHKUMBR MUTTATH

FEB 16 2007

D0058290

, 5711 SARVIS AVE SUSTE 200, RIVERDALE, MD 20737

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** DAVIS HELEN JANE 8:00 P M February 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AT WILLIAMSPORT HOMEWOOD Williamsport Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 72 215-64-0078 Maryland Director July 4, 1934 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Washington Funeral Director Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? p a 23 West Baltimore Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iten Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Internated them "natural", or ite marked other than "natural", or ite marked other than "natural", or other traumatic event, the Medical Examine any or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Aide Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Harbaugh Lillian 2 Brill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane J. Davis 445 Edgewood Drive, Hagerstown, Maryland 21740 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 02-21-07 22. Name and Address of Facility 40 Andrew K. Coffman Funeral Home, East Antietam Street, hagerstown, 21. Signature of Funeral Service Licensee R. hoel Bran 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Muca **Physician** /Medical Due to as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner that initiated events resulting in death) Last The law requires that the death certificate be execut burial-trar Due to (or as a consequence of) P.O. Box 68760. the as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months2 1 ☐ Yes 2 ☐ NO Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the undeflying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by XITT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Natsing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I hours after death. uneral Director: A sly filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signati 29d. Date/signed (Month, Day, Year) account

State Registrar

154-2

30. Name and address

31. Date filed (Month, Day,

Year)

FEB

20

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type\_Print)

32. Registrar's Signature

			For State Registrar	State of	Maryland		artmen rtificat			and M	-	giene	00	O I Company	06270
	Dharaini		1. Decedent's Name (First, Middle	e, Last)			<u></u>		-		2. Date of De	ath		Vone	3. Time of Death
E	Physici /Medio		John Edward D	udas							Februa	ry Î	1, 2	ÖÖ7	2:05A M
	Examin		4a. Facility Name (If not institution						Location of	of Death			County o		
			Montgomery Gene				01ne	-	Milleden	2411-				mery	
	Funeral Director		5. Social Security Number 203–30–4437	6. Sex 1∭ M 2□ F	7. Age (In yrs. Ias 67	Yrs.	If Under Months		If Under : Hours	Min.	8. Date of Bir (Month, Da Feb. 7	$\stackrel{\text{th}}{\stackrel{\text{y}}{\stackrel{\text{y}}{\stackrel{\text{y}}{\stackrel{\text{y}}{\stackrel{\text{o}}}{\stackrel{\text{o}}{\stackrel{\text{o}}{\stackrel{\text{o}}{\stackrel{\text{o}}{\stackrel{\text{o}}{\stackrel{\text{o}}}{\stackrel{\text{o}}{\stackrel{\text{o}}}}{\stackrel{\text{o}}}}}{\stackrel{\text{o}}}}}{1.00}}}}}}}}}} 19$	40	9. Birthpl PA	ace (State or Foreign try)
	p >		Usual Residence of Decedent  10a. State 10b. County		100 City 3	r									
	shov	2			10c. City, 1		cation							10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Funeral Director	MD Montgo	mery	Rockv	ılle	10f. Zip	Code				10a Citis	on of Mi	not Cour	
	with 3e or	0	15310 Georgian	Square Ct	_		208					10g. Citiz	ON OF AM	nat Coun	try ?
	death ma 23	era	11. Marital Status		dent Ever in U.S. ces?	13. \			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race	- America	an Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Itema 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be nailfied at once.	Fur	1 ☐ Never Married 2 ☐ Marr	ied 1XTYes	2 □ No		fYes,spec 1 □ Yes :		n, Mexican Specify:	, Puerto	Rican, etc.)			, White, e	
8	ure!',	d by	3 ☐ Widowed 4 ☐ Divorced		tes:1956-6	2	10 162 /	ZALI NO	зр <del>о</del> спу.				Specify:	Whi	te
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12	withi ene. then	d L	Elementary/Secondary (0-12)	College (1-		arket						Marke	etin	g/Ad	vertising
0	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle,			ar 100 c				r's Name	(First, Middle,				
Maryland 21215-0036	uld be Aental rked tic ev	To B	John Walter Dud	las					Mary	Gay	dos				
ary	and h		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City or	Town, S	tate, Zip	Code)
Σ.	and sealth m 27		Christopher M.	Dudas/son						-	Alpine,	CA S	9190	1	
Baltimore,	ges 1 t of H if ite		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation	3 ☐Removal from S	state 20b. Plac	e of Dispo etery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Loc	ation - C	ity or To	wn, State
Ë	t. Partmen		4 Donation 5 Other (Specify) Chesapeake Crematory C									Belt:			
Bal	Department of the partment of		21. Signature of Funeral Service-Licensee  C3 Name amonthe soci Facility  MO12 5 1 Programme The Live Service												
			23a, Part1, Enter the disease, or	MO1251Beverly L. Heckron  3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card									rksv	ше	Approximate
ı	Dhysisian		Immediate Cause (Final	only one cause on ea	ich line.										Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (c	VOSC/Ero	ΠC (	ard	1040	scu	ar	Usea	12		-	years
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	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (d	or as a consequer	ice of):									
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Вох	death certifica attending pt d for use as ti	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnancy	,						2:	3d. Date	of deliver	v
Ö	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2 Fetal de int at time of deat		Ectopic pre Other (spe						Mont		Day Year
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a	n: The	င္ပ	25. Was case referred to medical								1 Tes	2 No		Yes 2	2□ No
₹	s cert directe	0 8	examiner?	Hospital:	patient 2 ER	/Outpatient	3 DO	Othe	r		(Check only o	-		(0 1	
1 0	Attending Physician: If death. Sector: After this certific by the funeral director.	i i	27. Manner of Death	28a. Date of		b. Time of		Bc. Injury Work			ne 5 Resid				
<u>o</u>	ath. or: After	atio	1 Accident 5 Pending investig	ation	, Day Teal)	Injury	м		r es 2□N	ło					
Division of Vital Records,	after death Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 28e. Place	of Injury - At home g, etc. (Specify)	, farm, stre	et, factory	, office		2	8f. Location (S City or Tox	Street and vn. State)	Number	or Rural	Route Number,
Ω	ospital o	S													
	To the Hospital within 24 hours and to the Funeral I completely filled	edicai	29a. Certifier Certifyin (Check only one)	g Physician: To the t Examiner: On the bas and manne	sis of examination	dge, death and/or inv	occurred a restigation,	at the time in my opi	e, date and iñion, deatl	l place, a h occurre	nd due to the ed at the time,	cause(s) a date and p	ind manr place, an	ner as sta d due to t	ited. the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death, to the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (	Month, D	ay, Year)
			All ulul	rolson			J.D	ממו	1847	19	c	Folor	Alex-	11 1	2007
5+	1 1			who completed cause	of death (Item 23	a) (Type, I	Print)		0 1 0	, ,		0010	cary	11/1	, , ,
	66		1 70 70 100	200 /810	Kince	rhill	ip Dr	VL	0/1	ey.	maryl	and			
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 1.5	2007	gistrar's Signature	A	nerte	,		,					
		E.G.  State Registrar  And Dood 19 10 10 10 10 10 10 10 10 10 10 10 10 10													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician**  $P^{M}$ February | Howard Martin Dowling 11 2007 /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1500 Edmondson Ave. Baltimore Catonsville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 90 Yrs. 5. Social Security Number **Funeral** Days 15 M 2 ☐ F Maryland Director 12/29/1916 705-05-3207 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or Itams 23s or 28e-f ehow the Medical Examiner must be notified at 1 Yes 3 No Director Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 Edmondson Ave. 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Superintendant of Shop CSX Railroad and Mental Hygie is marked other permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, 90cs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine G. Dore Howard E. Dowling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine R. Dowling/daughter 620 Sherwood Rd. Cockeysville, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Meadowridge Mem. Park 2/17/2007 1 € Burial 2 Cremation 3 Removal from State Elkridge, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Partf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN Months Physician M GTA STAN DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **X**No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel within 24 hours a To the Funerel D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier a2 Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank 32. Poistrar's Signature 31. Date filed (Month, Day, Year) State FEB 15 2007 Registrar DHMH 17 Rev 1/2001

			for State Registrar	State	of Maryla		artment rtificate			and M	ental Hygi	ene () (	7	06272
	Physici	an	1. Decedent's Name (First, Middle		_						2. Date of Death Month	Day	Year	3. Time of Death
	/Medic			Duckwort							Februar	y 14, 2		5:50 A M
	Examin	er	4a. Facility Name (If not institution						Location of	of Death		4c. County		
			Egle Nursing a					acon	_	0411==		Alle		
	Funeral Director		5. Social Security Number 217–28–9647  Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F		s. last birthday) Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, Aug. 11	<sup>Yeer)</sup> 1932	COU	place (State or Foreign http:) Yland
	land		10a. State 10b. County		10c. C	City, Town or Lo	cation						T	10d. Inside City Limits
	Mary	ō	MD. Alle	egany		Lonacon	ing							1XXYes 2 □ No
	28a	Directo	10e. Street and Number				10f. Zip (	Code			10	g. Citizen of V	Vhat Cour	ntry?
	3a o	0	40 Main St.	, Apt. 30	7			2153	9			United	l Sta	ites
	deati	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			can Indian,
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5-003b	irel'.	d b	3 ₩ Widowed 4 Divorced	If Yes, ( Year or	Dates:		103 2	22110	эрвспу.			Specify	WILL	
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N	Hygie ther nt, II	မ င	12 17. Father's Name (First, Middle,	Last)		110	manasi		18 Mothe	r's Name	(First, Middle, M	eiden Sumam	۵)	111-111-111-111-111-111-111-111-111-111-111-11
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Maryland	permit. Pages 1 and 2 should be loppartment of Health and Mental Importent: If item 27 is marked o any injury or other traumatic eve once.	욘	19a. Informant's Name/Relations			19b. Mailir	a Address (	Street a	nd Numbe		l Route Number,		_	Code)
S	nd 2 :		Margaret Diane		ughter						on, Mary		2152	
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b.	Place of Dispo cemetery, cren	sition (Name	e of		D	ate 2	Oc. Location -		
Ê	Page ent o nt: If ry or		1 ☐ Burial 220 Cremation 1 ☐ Donation 5 ☐ Other (S		n State Cur	mberlan			ry	02/1 2007	4/ Cu	mberla	nd, I	Maryland
altımore,	mit.		21. Signature of Funeral Service		1				_ ,		l Funera	1 Home		
ň	permi Depa Impo any ir		1 / Mai	Re L	sal						ternport			21562
			23a. Part1. Enter the disease of shock, or heart failure. List	complications tha	t caused the dea									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause of	AFTAC	TATIC	111	NIZ.	CA	2 / in	ama		71	Onset and Death
	/Medical		resulting in death)	a. Due t	o (or as a conse	equence of):	- Cui	74 65	C/-)4	CCI			48	ow one see
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و ×	eath certific attending p	Me	IF FEMALE:	220 If yes c	utcome of pregr	22204								
X R Q	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	tal death 3 □	Ectopic pre					23d. Date Mor		ery Day Year
j.	at the de by the a	Physician/Med	1 □ Yes 2 Ū No 9 □ Unknown	9□ Unk	gnant at time of known	death 5∟	Other (spec	спу)		-				
<u>.</u>	that ed by deta	h P	Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying cau	use giver	n in Part I.		23e. Did toba	cco use contr	bute to th	ne cause of death?
Vital Records,	w requires that been signed to should be deta	d by	CHRONI	c ors	TRUCK	MYE.	Cuns	5 00	SEATI	7	1 🗆 Yes	2 🗆 No	3 🔲 Prob	abiy 4 Qunknown
င္ပ	w rec	lete	•/								24a. Was an	24b. W	/ere autor	psy findings available
T E	sician: The law certificate has l irector, page 2 s	Completed									autopsy performs	ag/? d	rior to cor eath?	npletion of cause of
		0	25. Was case referred to medica						26 Place	of Death	(Check only one)		☐ Yes	2LI N0
Ξ	ysici is cer direc	0 8	examiner? 1 ☐ Yes 2 ∰No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA	Othor			ne 5 ☐ Residen		r (Specify	0
ō	ig Ph ter th neral	T:U	27. Manner of Deth	28a. Dat	e of Injury onth, Day Year)	28b. Time of Injury	280	c. Injury :	at	-	8d. Describe how			<i>'</i>
Ō	endir ath. or: Af	atlo	1 Accident 5 Pendir investi	gation	, , , , , , , , ,	,,	М		es 2□N	lo				
DIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Plac	ce of Injury - At I ding, etc. (Spec	home, farm, stre	eet, factory,	office		2	8f. Location (Stre City or Town,	et and Numbe State)	r or Rura	l Route Number,
2	itel o	S								N.				
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kn basis of examin inner stated.	nowledge, death ation and/or inv	occurred at estigation, in	the time n my <i>o</i> pii	, date and nion, death	l place, a h <i>o</i> ccurre	nd due to the cau d at the time, date	se(s) and mar e and place, a	ner as stand and due to	ated. the cause(s)
	To t To tl	Ž	29b. Signature and title of certifie	г	^			License			290	I. Date signed	(Month, L	Day, Year)
	3		<b>•</b>	Head	m		1	26	90	7	F	ERUAD	24 11	4,2007
			30. Name and address of person	who completed car	use of death (Ite		Print)		·	`			(	• )
			Dr. Harjit Sid				, Cumb	perl	and,	MD.	Z15UZ			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1	5 2007	Registrar's Sign	nature	Carle 1	1						
			1 60 0		- April James Rate	Service Marylin	Stanfor.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 16:15 2 11 2007 Dave1uy /Medical Allan Donald Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HIOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹ M 2 □ F Yrs. Director 46 10-11-1960 Connecticut 040-42-9994 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ages 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hyglene.

If the PZ TS marked outber than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Director Wicomico Salisbury MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 308 Carey Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Donald Daveluy Doris Gauck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if item 27 Is any injury or other trau 308 Carey Avenue, Salisbury, MD 21804 Doris Daveluy - mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2-14-07 Salisbury, Maryland Wicomico Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Main Street, Salisbury, Maryland 21804 23a. Part. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No or Attending Physician: ours after death.

leral Director: After this certificatilled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1110 618

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month. Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			riease i	State of Maryla					-		-		
			1 - For State Registrar	Otate of Maryla				Death	Memai	Reg. P	21111	0627	1
	Physic	ian	1. Decedent's Name (First, Middle, Last)	E1				•	2. Date of Month	) [	Day Year	3. Time of Dea	
	/Medi	cal	Olive Peggy  4a. Facility Name (If not institution, give			4h Cih	/ Tours or	Location of Dea	Feb.		2007 4c. County of Dea	12:15	РМ
	Exami	ner	Mallard Bay Care			40. Oil		ridge	iųi		Dorch		
	Funeral	Г	5. Social Security Number 6. Sex		s. last birthday)	If Unde Months	or 1 Year Days	If Under 24 Hrs Hours Min	s. 8. Date of	of Birth h, Day, Yea 20,	9. Bir	thplace (State or For buntry) ry Land	reign
	Director		214-42-7956 LSual Residence of Decedent	M 20 76	Yrs.				Oct.	20,	1930 Ma	ryľand	
	Maryland -f show	_	10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Lin	
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$\mathcal{Z}$	3a or	2	10e. Street and Number 2604 Shane Circl	Le		10f. Zi	ip Code 21	613		10g. (	Citizen of What Co USA	ountry?	
2	death	nera	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Dece		spanic Origin? (s n, Mexican, Pue	Specify Yes	r No-	14. Race - Ame		
36 6	72 hours after death with the natural, or iteme 23s or 28s digal Exemitmen must be mutil	Completed by Funeral Director	1 Never Married 2 Married 3 Midowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1		2 No	Specify:	no Hican, etc	.)	Black, Whit		
8	2 hour	ed b	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usi	ual Occupa	ation		16h	Kind of Business	nite	
21215-0036	within 73 ene. then "ru	nple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of w DO NOT	ork done d use retired	turing most of wo	orking		71110 01 010111000	industry .	
21	filed wi Hygien ther th		9			Cra	ab Pi				Shellf:	ish	
and	be fill H at H of other	Be	17. Father's Name (First, Middle, Last) William Henry N	1cGlauchlin				18. Mother's Na	<sub>ime (First, Mi</sub> Len Cre				
Maryland	should be and Mental marked o umatic eve	ဥ	19a. Informant's Name/Relationship (Ty)		19h Maili	na Addres	s (Street s				or Town, State, 2	Zin Cada)	
	Pages 1 and 2 nent of Health a nut: if item 27 lanty or other tra		Cindy Bell/Daughte	•							Creek, 1		
ore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo cemetery, cres	sition (Na	ime of other place	e)	Date		Location - City or		
			4 □Donation 5 □Other (Specify)	ML				ery 2/1	5/2007	7 Hı	urlock, N	MD	
Bal	permit. Depertrimports ony inju		ignature of Funeral Service License	Demin	1 / 22	Qurra	nd Addres	s of Facility OMWe11 F St., Can	[unera]	L Home	e. P.A.		
			23d. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea	ith. Do not ent	308 E er the mo	de of dying	St., Can g, such as cardia	bridge c or respirato	ny arrest,	121613	Approximate Interval Between	
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	/Medical Examiner		resulting in death)	pue to (or as a conse	quence of):		/ .	,				2 week	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	chronic	065	truc	tive	ou la	manze	, di	SPAR		
o,	te be executed ysicien end e burial-transit		resulting in death) Last  Due to (or as a consequence of):										
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Вох 6	The law requires that the death certificate iste has been signed by the ettending physipage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn	ancy						23d. Date of deli		
œ.	ne death the etter hed for u	Iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	]Ectopic p ] Other (s					Month	Day Year	
P.O.	that the d ed by the detached	Phys	9 Unknown	9□ Unknown									
ds,	iuires tha r signed I ld be det		Part II. Other significant conditions con  hyperten hy	tributing to death but not re	sulting in the u	nderlying	cause give	n in Part I.		Oid tobacco		the cause of death?	
COL	w requ	letec	197										
of Vital Records,	The lav	Completed by							a	Vas an utopsy erformed?	prior to death?	topsy findings availa completion of cause	of of
ital	tifice ctor, p	BeC	25. Was case referred to medical					26. Place of Dea	1 ☐ Ye		lo 1 Yes	2 No	
> (	Physician: rthis certifica ral director, I	Tof	examiner? 1 Yes 2 No	ospital: 1 [] Inpatient 2 [	ER/Outpatien	t 3 🗆 D	Othe			1	6 ☐Other (Spec	erfy)	
חכ	D 0 0	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work		28d. Descr	ibe how inj	ury occurred		
Division	of or Attending the ester death. I Director; After d in by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre	M eet factor		es 2 □No	28f Locatio	on (Street a	and Number or Ru	ral Route Number,	
<u></u>	2 2 2 2	Certification;	4 Homicide	building, etc. (Speci	(y)		,, 511100		City or	Town, Star	te)	al mode rember,	
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical (	29a. Certifier 1 Certifying Phys	ician: To the best of my kn	ation and/or inv	estigation/	in my op	inion, death occu	urred at the tir	ne date ar	nd place, and due.	to the cause(e)	
	vithin 2 vithin 2 To the f complete	Med	29b. Signature and title of certifier	and manner stated.		29	c. License	number		29d. D	ate signed (Month	Day Year)	
) '	- s ⊢ ō		popolarso	71 100			HO	0599	73	2/	112/07	,/	
			30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,	Print)	_			,			
				150n 100	Dra 1	nbl	e 5+	Can	nbrid	se.	MD	0/6/3	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Lon	C)					Old /3	

		Amend 23a, PI per MD, g	State of Maryla 3865, 3/15/07 TT	nd / Departm <i>Certific</i>	ent of Health and ate of Death		jienę () (	07	06275	
		1. Decedent's Name (First, Middle, Last	")			2. Date of Dea	th		3. Time of Death	
	Physicia	KUIH	FOGLE			Month 02	Dey 12 2	007	12:30P	
To a	/Medica Examine	An English Manne (Mant Institution of the	street and number)		4b. City, Town,	or Location of Death	4c. County			
A. C.	LXumme	623 STILLWATER PI	LACE		BOWIE		PRINC		₹GE	
	Funeral	5. Social Security Number 6. Se	x 7. Age (In yrs		nder 1 Year   If Under 24 H	rs. 8. Date of Birth	1		ce (State or Foreign	
	Director	577-78-0805	□M 2 XF 49	Yrs. Mont	hs Days Hours M	frs. 8. Date of Birth (Month, Day 08-05-19	957 V		GTON, DC	
		Usuel Residence of Decedent								
	ylen M m	10a. State 10b. County 10c. City, Town or Location MD PRINCE GEORGE MITCHELLVILLE								
	W	MD PRINCE GE	LORGE MI	ICHELLVILL	Ŀ				1 Yes 2 □ No	
	7.28 F	10e. Street and Number		10f.	Zip Code	1	0g. Citizen of V	Vhat Countr	y?	
	riter death with the Mar ritems 23a or 28a-f si inper must be notified	623 STILLWATER PLA	ACE	2	0721		U.S.	Α.		
	deat	11. Marital Status	12. Was Decedent Ever in U	J,S. 13. Was De	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-		e - Americar		
9			Armed Forces? 1 ☐ Yes 2 🔯 No			erto Rican, etc.)		k, White, et		
2	al', o	3 ☐ Widowed 4 ⚠ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 2⊠ No <i>Specify:</i>		Specify	: BLACK		
0200-91212	filed within 72 hours efter death with the Maryland Hygiene.  Wher than "natural, or items 23a or 28s-f show ent, the Medical Examinet must be notified at the Medical Examinet must be notified at	15. Decedent's Edu (Specify only highest grad	cation	16e. Decedent's L	Isual Occupation	working	16b. Kind of Bu	ısiness/Indu	stry	
7	thin a second	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done during most of v Tuse retired)	VOIKING	PRIVA	ГF		
7	Hygien ther the		4yrs	LIBRARIA	N		1 1(1 V11.	L 1.7		
פ	be filed within 72 hours effer death with the Maryler tal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Documents.	17. Father's Name (First, Middle, Last)				lame (First, Middle, I	Maiden Surnam	e)		
<u>X</u>	should be ind Mental ind Mental inmarked o	BENJAMIN BLACKMON			LOUISE	THOMPSON				
Maryiand	2 shc end sum	19a. Informant's Name/Relationship (T)			ess (Street and Number or					
	5 4 2 E	WINONA BLACKMON/SI	STER-IN-LAW	9421 CHA	DBURN PLACE	GATTHERSBU	JRG, MD	20886	1	
saitimore,	of H	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition ( cemetery, crematory (		Date	20c. Location -	City or Tow	n, State	
Ě,	Peg nent sint: I	4 □ Donation 5 □ Other (Specify)	HAI	RMONY CEME	TERY	2-20-07 I	LANDOVE	R, MD		
<u> </u>	mit. Portr y Inj	21. Signature of Funeral Service Licens	ee //			JB JENKINS			E	
D	permit. Peges 1 e Depertment of Hee Important: If Nem any Injury or othe pace.	K. B. M-I	all	7474	LANDOVER RD	LANDOVER,	MD 2078	35		
		23a. Part1. Enter the diseese, or compleshock, or heart failure. List only or	ications that caused the dear	th. Do not enter the n	node of dying, such as card	iac or respiratory arre	est,	A	pproximate	
À F	hysician	snock, or neart failure. List only of	_					lr C	nterval Between Onset and Death	
	/Medical	Immediate Cause (Final diseese or condition	Brain Cance METASTATIO		ANGER			1		
	Examiner	resulting in death)		or as a consequence				l ì		
			200.00 (	5, 45 a 55,155 q 55,155				1		
E.	certificate be executed ding physician end use es the buriel-transit	Sequentially list conditions.	Due to (c	or as a consequence of	of):					
ر ک	an e lan e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury						1		
00/9	physicia physicia sthe bur	that initiated events resulting in death) Last	Due to (c	or as a consequence of	of):					
õ	ng pt	Tooding in dodiny East						1		
Š	v requires may me dearn certific been signed by the attending p should be deteched for use es letted by Physician/Me.		J				4			
	ed for u	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyin	g cause given in Part I.	23b. Dld to	bacco use con	tribute to th	ne cause of death?	
	requires that the een signed by the hould be deteched by the place of					1 □ Ye	s XXNo	3 Probal	bly 4 Unknown	
ń	igned igned be de					_				
0	the law require set has been signed as the page 2 should Completed					24a. Was ar		24b. Were	autopsy findings	
	s be 2 sh							comp of dea	eletion of cause ath?	
	ne law ete has t page 2 s					1 □ Ye	s 2 No	1□ )	∕es 2□No	
	entifice actor, p	25. Was case referred to medical			26. Place of D	eath (Check only one	9)			
> 3	r this certific rel director.	examiner? 1 ☐ Yes 2 ☑ No	lospital:	ER/Outpatient 3	Out	Home 5X Reside		r (Specify)		
9	erthi ierel	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe ho				
5	e fun e	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	1 ☐ Yes 2 ☐ No					
2	by th	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, fact	ory, office	28f. Location (Str	eet and Numbe	or or Rural R	loute Number,	
5	is of Attending Process of State of Sta	4 Difficide	building, etc. (Specif	<b>y</b> )		City or Town	, State)			
9	hour hour ly fill a	29a. Certifier  (Check only 2 Medical Example	iclan: To the best of my kno	wledge, death occurre	ed at the time, date end place	ce, and due to the ca	use(s) and mar	ner as state	ed.	
Ì	To the Tooppus or Attending Projectent: The law within 24 hours effect deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comp	one)	er: On the basis of examina and manner stated.	tion end/or investigati	on, in my opinion, death oc	curred at the time, da	ite and place, a	nd due to th	e cause(s)	
	Z vith	29b. Signature and title of certifier	1 11	2	29c. License number	29	d. Date signed	(Month, Da	y, Yeer)	
	de	therein Glo	1555 - Shen	endo	D28079		2/14	107	,	
	(11)	30. Name end address of person who co	mpleted cause of deeth (Item	23a) (Type, Print)			7./	/		
	(10)	trancine A. His	6-5-5HIPMA	7-9200	Basil Cou	rt-Lare	10, MD	20	774	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		-				

DHMH 16 Rev 6/95

				artment of Health and Ment	tal Hygiene	007 06276						
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Mary Evelyn Fitz		ate of Death footh 20.15,20	0.7 Year 3. Time of Death 2:45a M						
	Examin	er	4a. Facility Name (If not institution, give street and number) Julia Manor Nursing Center	4b. City, Town, or Location of Death Hagerstown	4c. Co Wa	ounty of Death shington						
	Funeral Director		5. Social Security Number $175-03-2383$ 6. Sex $1\square$ M $2\cancel{\mathbb{R}}$ F 8. Age (In yrs. last birthday Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Do A	ate of Birth Month, Day, Year) Oril 2 9	9. Birtholace (State or Foreign MD						
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MD Washington Clear			10d. Inside City Limits						
	ith the M or 28a-f	Directo	10e. Street and Number	10f. Zip Code		1 ☐ Yes 2 ☒No						
	death w	neral	12440 Indian Springs Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican								
900	ours after ral', or lte	d by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 Yes 2 <b>X</b> o Specify:	white							
21215-0036	d within 72 h jiene. r than "natu ir e Medical	Completed by Funeral Director	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) memaker		of Business/Industry idence						
land	ild be file lental Hyg kad othe Ic evant,	To Be C	17. Father's Name (First, Middle, Last) Charles Howard Moore Sr.	18. Mother's Name (Firs Mae Sen	it, Middle, Maiden Si nsenbaug	·						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or othar traumatic evant, it a Medical Examinating must be millind at once.		19a. Informant's Name/Relationship (Type, Print)  Joyce Stuff daughter 731	ing Address <i>(Street and Number or Rural Rou</i> 1 Renninger Rd.Mer	nte Number, City or 1	Town, State, Zip Code) g, PA 17236						
Baltimore,			20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	osition (Name of practice) practory or other place) Feb. 19 2007	Hage	ation - City or Town, State erstown, MD						
Balt	permit. Departi Import any inj	1	21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Part 1. Enter the disease, of complications that daused the death. Do not en	2. Name and Address of Facility Donald Edwin Thom P.O.BOX 310 Clear	npson Fun Spring,	neral Home, Inc						
	Physician			ter the mode of dying, such as cardiac or responses	piratõry arrest,	Approximate Interval Between Onset and Death						
	/Medical Examiner		Due to (or as a consequence of):		Disea	se						
,00	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):	al Fibrillatio	'n							
κ 68760,	tiffic as	Medica	d									
P.O. Box		Physician/Medical	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)	230	d. Date of delivery Month Day Year						
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use	contribute to the cause of death?						
Division of Vital Records,	The ate h page	Completed			4a. Was an autopsy performed?  ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No						
of Vita	Physician: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		5 Residence 6							
ision	fter me	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.  28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time (Month, Day Year)	Work? M 1 □ Yes 2 □ No	Describe how injury of							
ο	ie Hospital or Attendi 124 hours after death. 19 Funeral Director: A letely filled in by the fu		4 Homicide building, etc. (Specify)	C	ity or Town, State)	Number or Rural Route Number,						
	To the Hospital within 24 hours a To the Funeral completely filled	Medical										
	Miles OCO		29b. Signature and title of certifier	29c. License number	02	Signed (Month, Day, Year)						
ک	H-C		30. Name and address of person who completed cause of death (Item 23a) (Type	Heaves	rt.wh	mn 21740						
	Sta Registr		31. Date filed (Month FEB 2 0 2007 32. Redistrar's Signature	perk								

			1 - For State Registrar	State of M	aryland				lealth a		lental Hy	gien Reg. N	200	17	0627	7
ı	Physici		1. Decedent's Name (First, Middle, Last  Paris of FRA	NKS							2. Date of De Month Fe bruar	Da	Δ	Year	3. Time of Death	A
	/Medic Examin		4a. Facility Name (If not institution, give Howard County Hos	street and number)				Town, or	Location o	of Death	10,000		c. County of	of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Funeral Director		5. Social Security Number 6. Se		je (In yrs. la	st birthday) 77 Yrs.	If Unde Months	n 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6/24/	rth ay, Year 1929	-)	9. Birthp	place (State or Foreigntry)	in C
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  Howard			Town or Lo								1	0d. Inside City Limit	
	with the a or 28s	Director	10e. Street and Number				10f. Zip		1045			-	itizen of W	hat Cour	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than *natural', or Itams 23e or 28e-f ahow any highly or other traumatic avant, the Medical Examinar must be notified at ance.	by Funeral	8505 Moon Glass Co  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 12 Yes 2 15 If Yes, Give Year or Dates:			Was Dece I Yes, spe	dent of H			pecify Yes or No- Dican, etc.)		14. Race	- Americ , White,		
1215-0	within 72 ho ane. then "netur	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or	5+)		kind of wo DO NOT u	ork done d se retired	during mos			16b. I	Sb. Kind of Business/Industry			
Maryland 21215-0036	id be filed tental Hygie ked other ic avant, it	To Be Co	12 17. Father's Name (First, Middle, Last) David Ransom F	6 ranks		SOIT	ware	Eng		er's Name	(First, Middle		Private Maiden Sumame) Duncan			
Mary	nd 2 shoul aith and Ma 27 is mari r traumati		19a. Informant's Name/Relationship (7) Kathleen Franks/D	rpe, Print)	(	195 Mailin 8505 01 umb	Moon Moon	Gla aryl	and Number SS Co and 2	r or Bura 1045	i Route Numb	er, City	or Town, S	State, Zip	Code)	
Baltimore,	Pages 1 a nent of He ant: if itam ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,			cemetery, crematory or other place)					)ate /2007		c. Location - City or Town, State			_
Balt	Departi Departi Importi any inji		21. Signature of Funeral Service Licens	uce MUI		55	38 M	ar1b	oro P	ike	Foresty	7 <b>i</b> 11		y1ar	nd 20747	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each li a Due to (or as	Ga	estri				cardiac c	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
8760,		Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Die to (or as a consequence of):  c. Due to (or as a consequence of):  d.														
P.O. Box 68	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Yo		100
	w requires that the de- been signed by the a should be detached to	ğ	Part II. Other significant conditions co		ut not result	ting in the ur	nderlying o	cause give	en in Part I.				use contril		ne cause of death? ably 4 ②Unknow	n
Division of Vital Records,	The law recate hes because 2 sho	Completed	Respiratory 1	Tailore							24a. Was auto perio	psy prmed?	de	ath?	psy findings available inpletion of cause of 212 No	Э
Vita	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2∏E	R/Outpatien	t 3 🗆 DC	Othe			ne 5 ☐ Resi	-	€ □Othor	(Canak	a	
sion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ry 2	28b. Time of Injury		28c. Injury Work		2	28d. Describe				0	
Ö	ospital or Attandospital or Attandospital biractor: Infilled in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	c. (Specify)						City or To	wn, Stat	θ)		l Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the hest ner: On the basis o and manner sta	f examinatio	ladge, death on and/or inv	estigation	at the tin , in my of	ie, date an pinion, deal	d place, t th occurre	at the time,	date an	d place, ar	ner as st nd due to	ated. the cause(s)	
}	To the To the comp	W	29b. Signature and title of certifier	140			290		0063	65	3		te signed			
_	6)		4.00			23a) (Type, 1 Lone					land Ze		5			
12	Sta Registi		31. Date filed (Month, Day, Year) FEB 15 2007	32. Registr	ar's Signatu	13.0	7									

			For State Registrar	State	of Mai	ryland / D	epa <i>Cen</i>	rtment tificate	of He	ealth a Death	nd M		giene Reg. No		17	062	78
	Dhi.a.i		1. Decedent's Name (First, Middle,	Last)								2. Date of De Month			Year	3. Time of	Death
	Physici /Medio		Mary Jane Freder	ick								2	1.			6:45	$A^{M}$
	Examir	er	4a. Facility Name (If not institution, 3 Mary's Ct.	give street and n	umber)			4b. City, To Fink			Death		4c. County of Death Carroll				
	Funeral Director		5. Social Security Number 218–24–1659	i.Sex 1 ☐ M 2 <b>]X</b> ]F	7. Age	(In yrs. last birti	rhday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 12/10/	ly, Year)	9	Cour	place (State ontry)	or Foreign
	D .		Usuel Residence of Decedent  10a. State 10b. County		· T ·	10c. City, Town	orlos	ation									
	ehov •	้อ	MD Carrol	1		Finksbu		ation							1	0d. Inside C	
	the N	Director	10e. Street and Number					10f. Zip C	ode				10a. Citi	izen of V	Vhat Cour		
	h with	i D	3 Mary's Ct.						048				_		state	•	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23s or 28e-f ehow sumatic event, the Madical Examinational Contilling at	Funerai	11. Marital Status 1 Never Married 2 Marrie	12. Was Dec	orces? 2[ <b>V</b> No		lf.	/as Deceder Yes, specify	y Cuban	spanic Origin, Mexican,	n? (Spe Puerto I	cify Yes or No Rican, etc.)		Black, White, etc.			
8	ure!',	d b	3 ∰Widowed 4 □ Divorced	Year or											Whit		
21215-0036	within 72 ane. than "nat	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	) (1-4or 5+)		(Give k life. D	ent's Usual ( and of work O NOT use	Occupat done du retired)	tion uring most (	of workir	ng			isiness/Ind	dustry	
2	Hygie Hygie other		17. Father's Name (First, Middle, La	est)		HO	mem	aker		18. Mother	s Name	(First, Middle,		Sumam			
Maryland	Mental Merked or	To Be	Owen Lewis Norr	is						Norn	na E	lizabet	h Ka	arn	,		
ary	is 1 and 2 should by Heelth and Men Item 27 is marke other trsumatic.		19a. Informant's Name/Relationshi	(Type, Print)								/ Route Numbe					
	and 2 eelth m 27 i		Pamela J. Austi	n – Daug	hter	and the same of th					-	estmins	ster,	MD	2115	57	
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3	□Removal from	State	20b. Place of cemetery				1		ate	20c. Lo	cation -	City or To	wn, State	
<u>=</u>	it. Pa rtmen rtant: njury		4 ☐Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li			Carriso							Owir	ngs 1	Mills	s, Mar	yland
Ba	permit. Pages Depertment of Important: If it eny injury or o		Steven 4	J. Elm		M00723	Ma	in Sti	reet	., Han	ıpste	ne Fune ead, Ma	ryla	Home and 2	e, 93 21074	4 Sout	th
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that nly one cause on	caused the	ne death. Do n	ot ente	r the mode o	of dying	, such as ca	ardiac o	r respiratory ai	rrest,			Approximat Interval Bet Onset and I	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. In	en	ny	W	D								1-11	4xbe
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dua to	(or as a	consequence o	it):										
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Registrar

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2007

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Martin L. Gogolski 2007 <u>February</u> 7:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Nov. 9, 1925 189-20-2556 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Virginia Fairfax Alexandria Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2911 Breezy Terrace 22303 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo if Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager <u> A&P Grocery</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benard Gogolski Mary Shap 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin Collar - Nephew 15531 Comus Rd, Clarksburg, MD 20871 20a. Method of Disposition
1 ☐ Burial 242 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Everly Crematory March 5, 2007 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Everly Wheatley Funeral Home 1500 W Braddock Rd Alexandria VA 22302 me 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician eas /Medical Due to (or as a lonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examiner law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1☐ Yes 1 ☐Yes 2 No 2 NO Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation ospital ... 4 hours at er dea... -val Director Affe 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 4,2007 D53654 M.D. 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Routiville, MD 20850 31. Date filed (Month, Day, Year) FEB 16 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 8:10 a M 2007 Zelda Mae Green Feb. 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Health Care Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Yrs Director 214-09-5702 95 April 3 1911 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heath and Mental Hygiene. Important: if Hear 27 is marked other than "natural" or items 23a or 28a-f show any injunt: it flem 27 is marked other than "natural" or items 23a or 28a-f show any injunt: or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 723 Spruce Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White <u>^</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Shoe Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Isaiah H. Green Mary Margaret Wagaman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Della Lane Ray Grove -Friend Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/20/07 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22) Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hapey Milue Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed hronic sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

J5H-7

State 31. Date filed (Month, Day, Year)

1126 Opal Court, Hagerstown, Maryland 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brew D. Sperk

Registra

Name known to physician: GATEWOOD, RAYMOND JAME

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Funeral Director		5. Social Security Number 6. Sec 219-28-0397	7. Age (In yrs. la			ours Min.	8. Date of Birtl	1932		place (State or Foreig
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permit. Pages 1 and i Department of Health Important: If Item 27 any injury or othar tr once.		20a. Method of Disposition	20b. Pla	ace of Disposition	(Name of	, and	ate	20c. Location	on - City or T	own, State
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i or Attanding Physician: The lav after death. Director: After this certificate has in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rt. City or Town, State)								
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	edical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	on and/or investig	ation, in my opinion	, death occurred	d at the time, d	ate and plac	e, and due t	o the cause(s)
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W.		Suresh Shandelya,	M.D. VA Maryla	and Heal	th Care S	ystem,	Perry F	Point,	MD 2	21902

State Registrar 31. Date filed (Month, Day, Year) FEB 1 4 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year Darryl John Gayon 14,2007 2:20a February 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7020 Heath Place Charles Welcome If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2 ☐ F Months 40 212-98-3963 Aug. 19, 1966 WashingtonDC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2X No Charles Maryland Welcome 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 20693 U.S.A. 7020 Heath Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Welder Construction Company 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William F. Gayon Sharon L. Brukhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William F. Gayon 7020 Heath Place, Welcome, Md. 20693 Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Premation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Funeral Service Alexandria, Va. 22. Name and Address of Facility
Williams Funeral Home, 21. Signature of Funeral Service Licenses 20640 Md Approximate Interval Between Onset and Death MUU668 4270 Hawthorne Rd., Indian Head, shock, or heart lating. List only one cause on each line.

MUU668 4270 Hawthorne Rd., Indian Head, shock, or heart lating. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) casa Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): F FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 Ro 1 ☐ Yes 2 ☐ No 1 ☐ Yes 5. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Scidence 6 Other (Specify) No 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 7. Manner of Death 28b. Time of Injury 5 ☐ Pending Vatural

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rithan "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturelt, or Itement injury or other traumatic event, the Medical Exemina-

Baltimore, Maryland 21215-0036

Funeral Director

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and attending physician the certificate After thi ours after death. neral Director: Af filled in by the fur

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital Attending Physician:

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2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

within 24 hours a To the Funeral L Fo the Hospital Medical State Registrar

(Check only one) 29b. Signature and title of certifier

investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

03

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

32. gistrar's Signature 31. Date filed (Month, Day, Year) FEB 15 2007

			For State Registrar	State	of Marylan		artmen rtificat			and M		giene Reg. No.	007	062	84
	Dhysici	20	1. Decedent's Name (First, Middle								2. Date of De		Year	3. Time of	
4	Physicia /Medic		Ralph Michael F								Februa			4:11	Р. м
-	Examin	er	4a. Facility Name (If not institution	. •	mber)				Location o			4c. County of Dea			
Ш	* * *		2331 Bentonia (		7. Age (In yrs.	last birthday)		Forestville, MD If Under 1 Year   If Under 24 Hrs.   8. Date of Birth					Prince Georges		
4	Funeral Director		578-66-4719	6. Sex 1 M 2 ☐ F	58	Yrs.	Months	Days	Days Hours Min. (Month. Day. Year) Coun.					ntrv)	or r Greign
	D		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County Maryland Prince	Georges	1	y,Town orLo restvi									•
	8a-1	Director						0-4-			1	10- Oili-	( ) ( ) ( ) ( )		2 110
	with t	ä	10e. Street and Number 2331 Bentonia (	ourt			10f. Zip					•	9. Birthplace (State or Foreign Country) DC  10d. Inside City Limits 1		
	eath	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.			spanic Orio	gin? (Spe					
0	r Iten	표	1 ☐ Never Married 2 ☐ Marr	Armed F ned 1 ☐ Yes	orces? 2 X No	1				, Puèrto	ecify Yes or No Rican, etc.)	}			
m O	ral', o	l by	3 ☐ Widowed 4 ☑ Divorced	If Yes, G Year or I	ve Dates:		1 🗆 Yes	ZALI No	Specify:			S	pecify: D12	1CK	
2-0	72 h	Completed	15. Deceden (Specify only higher	t's Education st grade completed,		16a. Dece (Give	kind of wo	k done d	luring most	of worki	ng	16b Kind Dist	of Business/Ir	Colum	nbia
12	within	du	Elementary/Secondary (0-12)	College	1-4or 5+)	Truck	DO NOTus Driv		,			Gove	rnment		
2	Hygie Hygie other		17. Father's Name (First, Middle,	Last)		Truck	DLIV	<u> </u>	18. Mothe	r's Name	(First, Middle	, Maiden Si	umame)		
an	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ind Mental Hygiene. Innekted other then "natural", or Itema 23e or 28e-f ehow umatic event, the Madical Examirer mainteen natitied at	To Be	Ralph Haley						Dor	is Tu	ıcker				
ary	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatice		19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a	ind Numbe	r or Rura	I Route Numb	er, City or T	Town, State, Zi	Code)	20020
Σ.	1 and 2 Health tem 27 I		Valencia Y. Kir	ng (Daught					N /TOO						
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of Hi Important: If iter ony injury or ott		20a. Method of Disposition  1		State Lin	Place of Dispo cometery, cres ICOIN M	osition (Nari natory of a lemor 1	ne of the Place a 1	em. 2		07 07				
<u>=</u>	mit. Pertm pertm portal y inju		21. Signature of Funeral Service	Licensee 1		25	Name an	d Addres	s of Facult	Ymes.	, P.A.				
m	88 5 8		Karny h	· Hmn	2005		_				Fores	tvill	e, MD	20747	
(h.			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.									Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	- 6	ine	t				Oriset and	Death				
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):				,	, ,	. /	6		
		-	Sequentially list conditions, if any leading to immediate	b. Due to	(or as a conseq	uence of):	0 . 17	TN	, 1	41	erhip	ude	ms		
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							-		pristernis			
o Î	exec en and rial-tra	Еха	resulting in death) Last		(or as a conseq	uence of):									
8760,	The law requires thet the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical		d											
9 X	leath certifics attending pl	Med	IF FEMALE:	00. 1/		71		<u> </u>							
Box	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2 Feta	Ideath 3	Ectopic pr		N	,		23		,	Year
P. O.	thet the de led by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	nant at time of d nown	leath 5L	Other (sp	еспу)							
ت	thet the the the the the the the the the		Part II. Other significant condition	ons contributing to	leath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did 1	obacco use	contribute to	he cause of	death?
Division of Vital Records,	w requires thet been signed t should be det	ed by	RENAL L	incysi	s, R	ENT	14				1 🗆	Yes 2 🗆	No 3 ☐ Pro	bably 4 🗷	Unknown
000	s bee	plete	DisEns								24a. Was		24b. Were aut	opsy findings	available
ž	The law ste hes page 2 :	Completed		,								ormed?	death?	4 -	ause or
<u>I</u>	iiclan: Th certificete rector, pag	Be	25. Was case referred to medica examiner?								(Check only	one)			
5	Attending Physician: r death. ector: After this certifice by the funeral director, I	၉	1 1 No			ER/Outpatier								fy)	
u C	ding F	lon:	27. Manner of Death  1 Alatural 5 Pendir	· ·	of Injury oth, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	rat ⊲? Yes 2.∐i		28d. Describe	how injury (	occurred		
<u> S</u>	death death ctor: y the	ficat	2 Accident investi 3 Suicide 6 Could	not be 390 Plac	e of Injury - At h	ome, farm, str					28f. Location (	Street and	Number or Rur	al Route Nun	nber.
<u>S</u>	effer Dire	Certification:	4 Homicide determ		ting, etc. (Specit						City or To	wn, State)			
	To the Hospitel or Attending Physician: The within 24 hours effer death.  To the Funerel Director: After this certificete his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the land mai	e best of my kno casis of examina oner stated.	owledge, deat ition and/or in	h occurred vestigation	at the tim , in my op	ie, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s	5)
	To the within To the comple	Me	49b. Signature and title of certifie	)					number				signed (Month,		
)	(10)		· 4	- gen			1	~2	133	9:	2-9	21	14/	07	
	(10)		30. Name and address of person		ise of death (Iter	n 23a) (Type,	Print)						14/	20	002
1996	JA C		INDER J.  31. Date filed (Month, Day, Year)	1 /w , M	Registrar's Sidna	A/Se	r Pe	tm c	enen	te	10111	V Cup	ital .	TVE	· UC
*	Sta Registi		FEB 16 2007	haven .	Registrar's Signa	the same									

Division or Vital Records, P.O. Box 68760,

	-	State Registrar			Certificate of	Death		Reg. No.	1 06263		
Physicia	ın	1. Decedent's Name (First, Middle, La	ast)				2. Date of De Month		3. Time of Death		
/Medic	al		D. Hunter		T		7 12, 2007	1:45 A. ™			
Examin	er	4a. Facility Name (If not institution, give Southern Maryland Ho			4b. City, Town, o	or Location of Deat	h	4c. County of E			
Funeral		5. Social Security Number 6. S		(In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs	8. Date of Bir		Birthplace (State or Foreign		
Director		577–92–4669 Usual Residence of Decedent	1□M 2 <b>X</b> F	/. /	rs. Months Days	Hours Min.	November	th year) 9. 13, 1959	Maryland		
land ow it		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
e Mary a-f sho tified a	cto	Maryland Prince G	eorge's		For	estville			1 X Yes 2 □ No		
th with the 23a or 28 ast be no	al Director	10e. Street and Number 3409 Regency Park	WHY		10f. Zip Code	20747		10g. Citizen of What U.S.A.	t Country?		
urs a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 【▼No		specify Yes or No to Rican, etc.)	Black, V	American Indian, Vhite, etc. 31ack		
hin 72 hc e. in "natu Medical	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5-		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wo.	rking	16b. Kind of Busine	ess/Industry		
ed with	E 0	Elementary/occostratory (0-12)	4	·	Cashier			Today's Mar	n Clothing Store		
be file tal Hy d oth event	Be (	17. Father's Name (First, Middle, Last				18. Mother's Nar	, , ,	, Maiden Surname)			
i Men i Men narke	ဍ		. Hunter, Sr.		Estella Medley						
and 2 sh ealth and n 27 is n		Mr. Thomas A. Hunter, Jr. (Brother) 3509 Hubbard Road #T-2 Landover,						Number, City or Town, State, Zip Code) , Maryland 20785			
Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town cemetery, crematory or other place)   20c. Location - City or Town cemetery, crematory or other place)   20c. Location - City or Town cemetery, crematory or other place)   20c. Location - City or Town cemetery, crematory or other place)   20c. Location - City or Town cemetery, crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place)   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or other place   20c. Location - City or Town Cemetery, Crematory or Cemetery, Crematory or other place   20c. Location - City or Command   20c. Location - C									
permit. Departr Imports any inj		21. Signature of Funeral Service Lice	nsee		22. Name and Address 4339 Hunt Pl						
		23a. Va.1. Enter the disease, or comock, or heart failure. List only	nplications that caused one cause on each line	the death. Do n		-			Approximate Interval Between Onset and Death		
Physician /Medical Examiner		disease or condition resulting in death)		PER C	ALCAMIA	,					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	tastat consequence o	ic Break	st can	CEY				
ertificate be executed ing physician and e as the burial-transit	Examiner	Cause (Disease or injury that initiated events c									
ate be e hysiciar the buri	Medical E		d								
sertific ding p		IF FEMALE:	On Hung outcome								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and specially filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey		23d. Date of Month	delivery Day Year		
that the ned by detact	A P	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause gi	ven in Part I.	23e. Did t	obacco use contribut	e to the cause of death?		
w requires that the deben signed by the should be detached	ted by	13/19teral F	leural 6	ffusi	On		1 🗆 '	Yes 2 No 3	Probably 4 Unknown		
: The law cate has b page 2 sl	Completed						24a. Was autoj perfo 1 Yes	an 24b. Were prior clean deat 2 No 1	e autopsy findings available to completion of cause of h? Yes 2 No		
certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o	one)			
Phys r this ral dii	2	1 ☐ Yes 21 ☐ No  27. Manner of Death	28a. Date of Injur		patient oll box			dence 6 Other (8	Specify)		
ndIng th.	tion	11☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year) Ir	njury Wo	rk? ]Yes 2∐No	Zod. Describe	now injury occurred			
l or Atter after dea Director I in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of injubuilding, etc	ry - At home, far . <i>(Specify)</i>	rm, street, factory, office		28f. Location (3 City or Tou	Street and Number o wn, State)	r Rural Route Number,		
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  CertifyIng P	hysician: To the best o miner: On the basis of and manner sta	examination and	, death occurred at the t d/or investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
To the within To the Complex of the	Me	29b. Signature and title of pertifier	16.111		29c. Licens	se number		29d. Date signed (M	lonth, Day, Year)		
(T)		/ Mull	ylay.		D	52200	·	2/10	2107		
30		30. Name and address of person who				20725			· · · · · · · · · · · · · · · · · · ·		
Sta	te	AMit Suri, M.D. 75 31. Date filed (Month, Day, Year)	503 Surratts I 32. Registra	Coad Clint r's Signature	on, Maryland	20735	1				
Registr		FEB 16 2007	Breen D.	Sperke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Tofazzal Hossain February 16,2007 0435 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Suburban Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. Hours 1 ☑ M 2 □ F 578-31-573 72 11/30/1934 Bangladesh Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Md. Rockville 1 ☐ Yes 2 ☑ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bangladesh 20852 6 Shagbark 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Asian Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Import/Export Businessman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ungvailable Sirajul Hoque A.K.M. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Shagbark Court Rockville, Md. 20852 Rahman-daughter Rokeya 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/21/07 Family Cemetery Dhaka, Bangladesh 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary disease or condition resulting in death) Arrest Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown

**Physician** /Medical Examiner

> use as t the attending

detached

page 2 should be

funeral director.

filled in by the

þ

signed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

The law requires that the death certificate be executed

Box

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Records,

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Department of important: if any injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Hygiene.

12 should be filed what and Mental Hygie other traumatic event,

Pages 1 and 2 ment of Health a

Director

Funeral

Completed by

Be

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Examine

by Physician/Medical

Be Completed

Certification: To

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1∐ Yes

28d. Describe how injury occurred

23e. Did tobacco use contribute to the cause of death?

Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

Hasitha

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number J00557

1 TYes

2□No

29d. Date signed (Month, Dav. Year) 2/16/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 16 2007 State Registrar

Wickramasinghe 8600 Old Georgetown Rd., Bethesda, Md. 20814

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 1 9 2007 JeJuan Ann Hopewell erruare 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Doctor's Comm. Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 2 – 20 – 30 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🕅 F 56 579-66-8607 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Prince Georges Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20774 USA 10723 Castleton Turn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Reality Company Property Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James E. Mahoney, Jr. Doris G. Hairston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10723 Castleton Turn Upper Marlboro, 19a. Informant's Name/Relationship (Type. Print) MD Richard J. Hopewell/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cem. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2-15-07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Speqity) 21. Signature of Funeral Jepuing I censee 22. Name and Address of Facility 120 H Street NE B K Henry Funeral Chapel Wash, DC 20002 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final Massive disease or condition resulting in death) uence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Caaque 0 Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Injury 1 ☐ Yes 2 ☐ No

requires that the death certificate be executed burial-tran attending physician for use as the buria s been signed by the should be detached

page 2 this certificate has

director

funeral

Certification:

Medical

After

To the nospinal within 24 hours after death.

To the Funeral Director: After the funeral pay t

Box 68760.

P.O.

Division or Vital Records,

or Attending Physician:

Hospital

To the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Item 27 Is marked other than "natul other traumatic event, the Medical

1 and 2 should be filed within. Health and Mental Hygiene. Sem 27 Is marked other than "

Health tem 27

Department of h
Important: If Ite
any Injury or of

**Physician** 

/Medical

Examiner

Pages 1

Baltimore Maryland

Director

Funeral

Completed by

Be

2

with the Maryland

death

Physician/Medical 2 Completed Be 2

Examiner

IF FEMALE:

1 ✓ Yes 2 ☐ No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

O MOSER

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SuitoA, Greenbelt, mD. 20110 : 7305 Hanover Harkway 1105hi redi 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

FEB 16 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician a 2 re b 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ho1 Cross Silver Mon pring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03–12–1918 Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9 Birthplace (State or Horeign Country) **Funeral** 1 □ M 2 🔀 F Days Hours 250-40-1248 88 Director SOUTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits пs 23a or 28a-f show 1X Yes 2 No Directo DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5613 1st ST N.E. 20011 U.S.A by Funeral rral", or Items 2 Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 X Widowed 4 Divorced "natural" Be Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) TEACHER GOVERNMENT 5+ of Health and Mental Hygie fitem 27 is marked other i r other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELIJAH PRINGLE ALICE FRANCIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE N. GRAHAM/DAUGHTER 5613 1st ST N.E. WASHINGTON, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot XXBurial 2 Cremation 3 Removal from State MARYLAND NATIONAL 02-20-2007 | LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mo Om **Physician** 100 10408 /Medical Due to (or as a consequence of): Examiner DIYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burlal-transit mi Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death signed by the a d be detached fi 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 Yes 2 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death (Check only one, Other: 4 Nursing Home 2 No Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐Other (Specify) After this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Seff 1:3 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 🗌 Naturai 5 Pending investigation mounted Ursin Home within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1800 1 ☐ Yes 2 No Jan 30 2007 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Nursy System 4 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide manor Core nhierton hpa 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTONI B. GORAL, MD 10400 CONNECTICUT AVE KENSINGTON, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 12:10A WILLIE HENRY 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOX CHASE REHAB & NURSING CENTER SILVER SPRING

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. MONTGOMERY Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F 97 Director 7-28-1909 429-08-9635 ARKANSAS Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County show TY□Yes 2 □ No 'natural", or items 23a or 28a-f sh dical Examiner must be notified MONTGOMERY SILVER SPRING MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2015 EAST WEST HIGHWAY 20910 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: ģ BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than HOUSEWIFE PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be finand Mental H OSBORNE MULLEN GEORGIA ROARK ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ROSETTA EASTER/ DAUGHTER 417 CLOVIS AVE CAPITAL HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other PILGRIM CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 02-21-2007 MARIANNA, AK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Furieral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LEG GANGRENE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ ALZHEIMERS DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) Injury 5 Pending investigation after death.

I Director: A
d in by the fu M 1 ∏Yes 2 ∏No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled i 24 hours a 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2. To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed

ALAN SEGAL, MD

FEB 16 200

1517

HUGO CIRCLE SILVER SPRING, MD 20906

death (Item 23a) (Type, Print)

32. Registrar's 9 gnature

D52261

02-14-2007

			Please Type or Print in Black In	artment of Health and Mental Hyg	•
			1 - State	artificate of Dooth	4007 00290
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Dea	eg. No. th 3. Time of Death
	Physici		GEORGE FRANKLIN HORN, JR.	FEBRUA	$\frac{1}{1}$ 6, $\frac{1}{2}$ 007   2020 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			18538 BREATHEDSVILLE ROAD	BOONSBORO	WASHINGTON
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 $\square$ F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   APRIL 1	9. Birthplace (State or Foreign Country) 9, 1927 MARYLAND
			Usual Residence of Decedent	AIKID	1), 1)ZI HAKIDAND
	arylan ahow	_	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ith the Marylan or 28a-1 show	ecto	MARYLAND WASHINGTON	BOONSBORO	Og. Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show fra M. Jical Examiner must be motified at	Funeral Director	105.20 DDEATHEDCVITTLE DOAD	10f. Zip Code 21713	U.S.A.
	Jeath ms 23	era	18538         BREATHEDSVILLE ROAD           11. Marital Status         12. Was Decedent Ever in U.S.         13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
9	or Itan	五	Armed Forces?  1 □ Never Married 2 ☑ Married I □ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	Black, White, etc.
215-0036	72 hours after death w *natural, or Itams 23a	Completed by	3 Widowed 4 Divorced Year or Dates:		Specify: WHITE
15-	n 72 h	lete	15. Decedent's Education (Specify only highest grade completed) (Giver life	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	filed withi Hygiene. other than	шо	Elementary/Secondary (0-12) College (1-4or 5+)	OWNER	ELECTRICIAN
þ	other vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	·
Var	and Mental and Mental is marked o	10 E	GEORGE FRANKLIN HORN, SR.	BEULAH POMROY I	IORN
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiens. Department of Health and Menial Hygiens "natural", or Itams 23a or 28a-1 show important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, Itam Modeal Examinet or other be notified at any injury or other traumatic.			ing Address (Street and Number or Rural Route Number	
	1 and 2 Health am 27 I		SHERMAN HORN, SON 1730 20a. Method of Disposition 20b. Place of Disp	O6 BRANDEN TERRACE, HAGERS osition (Name of Date	STOWN, MARYLAND 21/40 20c. Location - City or Town, State
Jou	Pages nent of I int: If its iry or o		1 Comption 3 Pamount from State   cemetery, cre	unatory or other place) LL CEMETERY 2/21/2007	HAGERSTOWN, MARYLAND
Baltimore,	permit. Pag Department Important: I any injury o		4 Donation 3 Donat (Specify)		NATIONAL PIKE
Ba	permit. Departr Imports any inje			AST FUNERAL HOME BOONSBORG	A STATE OF THE PROPERTY OF THE
	17-11		23a. P. rt1. Enter the discusse or complications that caused the death. Do not en shock, or hear failure. List only one cause of each line.	nter the mode of dying, such as cardiac or respiratory arm	est, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Llury	Onset and Death
	/Medical Examiner		resulting in death)  Du (or as a consequence to be consequence)	11	
	_xanimer	e.	Sequentially list conditions, J. any leading to immediate b. Due to (or as a consequence of).	enosis, lyperce	sion
	uted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	
Ć,	e be executed rsician and e burial-transit	Examin	resulting in death) Last Due to (or as a consequence of):		
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89 X	ertifica ling ph e as t	Med	IF FEMALE:		
Вох	attend for us	lan/	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
Ö	y the d	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Office (Specify)	
ď.	The law requires that the death certificate ten be signed by the attending phys age 2 should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tol	pacco use contribute to the cause of death?
rds	en sig	ed b	Stobela Mellety	1 🗀 Ye	s 2 No 3 Probably 4 Miknown
oco	law re as be 2 sho	plet		24a. Was a autops	
of Vital Records,	(0 11	Con		perform 1 Yes	ned? death?
Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only on	
of	Phys r this ral dir	. To	1	int 3 DOA 4 Nursing Home 5 N Heside	once 6 Other (Specify)
Division	Attending r death. actor: After y the fune	ation	1  Natural 5  Pending (Month, Day Year) Injury 2  Accident investigation	of 28c. Injury at 28d. Describe how Work?  M 1 Yes 2 No	,,
Visi	I or Attendi after death Diractor: A	iffice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office 28f. Location (St City or Town	reet and Number or Rural Route Number,
O	rs after or as a Direction	Certification:	Sunding, sic. (Specify)	S.ly 31 7 311	, 514.67
	Hosp 4 hou Funai	Medical	29a. Certifier   1   Certifying Physician: To the best of my knowledge, dea   2   Medical Examiner: On the basis of examination and/or in		
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Med	and manner stated.  29b. Signature and title of certifier	29c. License number 2	9d. Date signed (Month, Day, Year)
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d	7		30 Marine and address of person who completed cause of leath (Item 23a) (Type	Priqt)	Unnuary 17 CO
			1-reduce It KASE my/11	U Mealla Campus Ra	110x1510hi)21/42
	Sta		31. Date filed (Month, Day, Year) FEB 2 0 2007 32. Tgistrar's Signature	Tide	O
	Regist	rar	FED 40 2001 Been D. P.	gara.	

			1 - For State Registrar	State of	f Marylan		artment of F		nd Mental H	ygiene Reg. No		06291	
			1. Decedent's Name (First, Mid	dle, Last)					2. Date of D	eath		3. Time of Death	
	Physici /Medio		DANIEL	WILSON	нΔ	RRISO	N		Month Februa	Da arv 1	y Year 5, 2007	6:55 A M	
	Examir		4a. Facility Name (If not instituti			MILLOU	4b. City, Town, o	or Location of		7,	. County of Death		_
			Alice Byrd Taw	es Nursing	Home		Cı	risfie	ld		Som	erset	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	, ,	If Under 1 Year Months Days			irth Day, Year)	9. Birth	place (State or Foreign	1
	Director		216-12-0548	1 <b>X</b> M 2□ F	93	Yrs.			April		1913 Mar		
127	pud *		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c Cit	y, Town or Lo	ecation					IOd. Inside City Limits	
	sho	5				,, , , , , , , , , , , , , , , , , , , ,						1 ☐ Yes 2 💢 No	
	the N	Director	Maryland  10e. Street and Number	Somerset			10f. Zip Code	well		10a Cit	tizen of What Cour		_
	with	2								log. on			
	eath	Funeral	3840 Evans D		dent Ever in U	.S. 13.		21824 Hispanic Origi	in? (Specify Yes or N	10-	USA 14. Race - Americ	can Indian,	_
10	r iten	Ξ	1 Never Married 2 Ma	Armed Fo	rces?	ŀ			in? (Specify Yes or N Puerto Rican, etc.)		Black, White,		
036	urs a	by	3   Widowed 4 □ Divorce	If Yes, Giv	10		1 ☐ Yes 2 ☒ No	Specify:			Specify: W	nite	
Ò	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examoner must be notified at	ted		ent's Education lest grade completed)		16a. Dece	dent's Usual Occup	pation	of working	16b. K	ind of Business/In	dustry	
215-0036	thin 7	Completed	Elementary/Secondary (0-12)		-4or 5+)	life.	DO NOT use retire	d)	or working				
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pu	be fil tal H d oth	Be	17. Father's Name (First, Middle	e, Last)				18. Mother	's Name (First, Midda	le, Maiden	Sumame)		
₹	should to nd Ment marked umatic	၉	Tankard Edward						Maxine Ev				_
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examerational Be notified at		19a. Informant's Name/Relation		( - · · · ·				or Rural Route Num				
	ges 1 and 2 it of Health if item 27 i		Daniel W. Harr 20a. Method of Disposition	rison, Jr.			otomac St	reet -	Crisfiel Date		aryland 2 ocation - City or To		
Ö	if of the or of or of		1 ☑ Burial 2 ☐ Cremation	3 Removal from	State	emetery, crea	matory or other pla				ocation - City or To	own, State	
Baltimore,	t. Pa rtmen rtant:		4 Donation 5 Other		Ewe				2/18/2007	[Ewe]	ll, Maryl	.and	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	et 2 F	INA	. 2	2. Name and Addre Bradshaw		s Funeral	Home	5		
			Mary Beth I 23a. Part1. Enter the disease,	Bradshaw -P	ruitt	h Do not an			reet - Cr		eld, MD 2	Approximate	
			shock, or heart failure. Li	st only one cause on e	ach line.		50.495	rig, sucir as d	ardiac or respiratory	arrest,		Interval Between Onset and Death	
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	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>									
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Вох	eath certific ettending pl for use as t	2	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnanc	v			23d. Date of delive	•	
	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		Other (specify)	·,			Month	Day Year	
P.0	res that the dei signed by the e i be detached f	h	9 ☐ Unknown										
	es th igned	Ď	Part II. Other significant condi	tions contributing to de	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?	
ord	w require been sign	Completed							- 1	Yes 2	No 3□ Prob	pably 4 □Unknown	
ec	law law las b	pie							24a. We	s an opsy	24b. Were auto	psy findings available impletion of cause of	,
= H	The law pate has	ő							per 1 ☐ Yes	formed? 2.⊠No	death? 1 ☐ Yes	2 □ No	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?				100		of Death (Check only	one)			
of \	hysi this c	2	1 Yes No			ER/Outpatier	IT 3LI DOA		sing Home 5 Re			ý)	_
Z C	fing f	lo	27. Manner of Death 1 Natural 5 ☐ Pend	anig	th, Day Year)	28b. Time o Injury	Wo		28d. Describe	now inju	ry occurred		
isic	Attending r death.	cat	3 Suicide 6 Coul		of Injuny - At h	ome farm st	eet, factory, office	]Yes 2□N		/Street ar	nd Number or Rura	Al Route Mumber	
Division of Vital Records,	after Direction by	Certification:	4 - Homicide dete	mined 286. Place	ng, etc. (Special	y)	eer, ractory, onice			own, State		ir riodia radiibar,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	C	29a. Certifier 1 Certify	ring Physician: To the	best of my kno	wledge, deat	h occurred at the til	me. date and	place, and due to th	e cause(s	) and manner as s	tated.	
	24 h Fur etely	edical	(Check only 2 Medic	al Examiner: On the b	asis of examina	ition and/or in	vestigation, in my	opinion, death	occurred at the time	a, date and	d place, and due to	the cause(s)	
	ompl	₩ We	29b. Signature and title of certif	ier			29c. Licens	se number		29d. Da	te signed (Month,	Day, Year)	
	F > F 0			V +	-0)		D	4800	75	5	2 15 20	07.	
			30. Name and address of person	on who completed caus	se of death (Iter	n 23a) (Type,	Print)				1 (		_
			1	rumbunathan				hwav -	Crisfield	d, Ma	ryland 2	1817	
129.4	∌ Sta	ate	31. Date filed (Month, Day, Yea	ar) 32. R	egiatrar's Signa	ature	•			.,		<del></del> :	_
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Op-22-2786   1   M 2   F   78   Vrs.   Months   Days   Hours   March   22, 1928   En	Seorge's Sinthplace (State or Foreign Country) field, N.C.  10d. Inside City Limits 1 12 Yes 2   No  Country? ates merican Indian, hite, etc.  Black
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20a. Method of Disposition    Security   Security   Security	
20a. Method of Disposition    Security   Security   Security	
Second   S	0748
Physician Medical Examiner  23a. Part 1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or conditions resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause (Enfer not death) Last  Due to (or as a consequence of):  Due to (or as a consequence o	
Physician Medical Examiner  23a. Part 1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or conditions resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause (Enfer not death) Last  Due to (or as a consequence of):  Due to (or as a consequence o	
23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (ist only one cause on each line.)  Immediate Cause (Final disease or condition resulting in death)  Jego 1	. 20747
Physician / Medical Examiner  The properties of the properties of	Approximate Interval Between
The dical Examiner   The string of the str	Onset and Death
Sequentially list conditions, if any, isading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a cons	
C. Due to (or as a consequence of):    Comparison of the control o	
C. Due to (or as a consequence of):    Comparison of the control o	
SO So So So So So So So So So So So So So	-
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   Page III Other significant conditions contributing to death but not resulting in the underlying cause in Red II   23e. If yes, outcome of pregnancy   23d. Date of   Month   Month   1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   23e. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   9   Unknown   9	
Q = EB   9   Unknown   9   Unk	1
O = E = 9   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Other significant conditions contributing to death but not resulting in the underlying course given in Red I. 23e Did tobaccourse contributing to death but not resulting in the underlying course given in Red I. 23e Did tobaccourse contributing to death but not resulting in the underlying course given in Red I. 23e Did tobaccourse contributing to death but not resulting in the underlying course given in Red I.	lelivery
	Day Year
	Probably 4 ₩Unknown
24a. Was an autopsy performed?  1	autopsy findings available o completion of cause of
The second of th	
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other ()	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred (Month, Day Year) 1 SAlatural 5 Pending	es 2 No
The state of the s	es 2 No
	es 2 No
	es 2□ No Decily)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.	es 2 No  pecily)  Rural Route Number,
(Check only one)  2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (M	es 2 No  Decily)  Rural Route Number,
Willy ( dame in DRC 206	es 2 No  Decily)  Rural Route Number,  as stated, ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	es 2 No  Decily)  Rural Route Number,  as stated, ue to the cause(s)
LITTING T TOWNER IN 11701 LIVINGON POR FIT WASHINGTON MA	es 2 No  Decily)  Rural Route Number,  as stated, ue to the cause(s)
State Registrar  31. Date filed (Month, Day, Year) Registrar  32. Registrar's Signature  34. Checken  35. Checken  36. Checken  36. Checken  37. Date filed (Month, Day, Year)  38. Registrar's Signature  39. Checken  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature  34. Checken  35. Checken  36. Checken  36. Checken  37. Checken  38. Checken	es 2 No  Decily)  Rural Route Number,  as stated, ue to the cause(s)

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

	riease i	Over a f Manualeur		· ·				•		-09.2.0.		
	for State	State of Marylan	_				and M	lental Hy	giene			
	Registrar		Cer	tificate	e of L	eath)			Reg. No.	200	1 06	293
an	1. Decedent's Name (First, Middle, Last)	)						Date of De     Month	eath Day	Year	3. Time of	Death
cal	Doloi	res M. H	lite_					Feb.1	2, Ž	007	10501	Э М
ier	4a. Facility Name (If not institution, give	street and number)		4b. City, 7	Town, or I	Location	of Death		4c. (	County of Dea	ath	
	Southern Maryla	and Hospital	L į	Clir	nton				Pr	ince (	George	
	5. Social Security Number 6. Se:			If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9. Bi	rthplace (State o	r Foreign
	121-24-4957	□M 2XF 75	Yrs.					8/3/P	1931	Ne	w Jerse	∋y
	Usual Residence of Decedent  10a. State 10b. County	100 Cit	, Town or Lo	nation							404 1-14-01	. 1: ::
-	Maryland Prince										10d. Inside Ci 1 ☐ Yes	
Sct		George op	per Ma	_								- <del></del>
ä	10e. Street and Number	_		10f. Zip						en of What C	ountry?	
<b>Funeral Director</b>	12427 Persimmon			207					US			
nue		12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Deced f Yes, spec	lent of His lify Cubar	spanic Ori n, Mexica	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Whi</li> </ol>		
N F	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1	☐Yes 2	2XNo	Specify:				Specify: W]	hite	
q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10.0									
lete	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	ent's Usua kind of wor OO NOT us	k done de	tion u <i>ring m</i> os	t of work	ing	16b. Kin	nd of Business	s/Industry	
E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Subst		,				Edu	catio	n	
Be Completed by	17. Father's Name (First, Middle, Last)		Dubs	.1040				e (First, Middle				
B	Frank McCaffre	0.17				Mari				Julianie)		
ဥ	19a. Informant's Name/Relationship (Ty		10h Mailia	a Address				Cosgr		T 04-4-	Zip Code)207	
	Richard E. Hite										lboro,	
	20a. Method of Disposition	·						Date		cation - City o		עני
	1 ☐ Burial 2 🛣 Cremation 3 ☐ F		lace of Dispo emetery, cren							-		
	4 □ Donation 5 □ Other (Specify)		las C			7	2/16	5/2007	Edg	rewate	r,MD.	
	21. Signature of Funeral Service Licens	The h									uneral	
	to face	20								III,M	D.2074	5
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the deat one cause on each line.	n. Do not ente	er the mode	e of dying	, such as	cardiac	or respiratory	arrest,		Approximate Interval Bet	ween
	Immediate Cause (Final disease or condition	Bronchopne	umoni	a							5 Day	S S
	resulting in death)	Due to (or as a conseq								-		
١.	Sequentially list conditions	Coagulopat									7 Day	s
nei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq										
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pulmonary		ism							2 Wee	ks
	resulting at death) Last	Due to (or as a conseq	uence of):									
ical		d										
Med	IF FEMALE:										1	
an/I	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pre	egnancy				2	3d. Date of de	-	
Sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at time of d 9□Unknown		Other (spe						Month	Day	Year
Physician/Medi	9 ☐ Unknown											
β	Part II. Other significant conditions co		ulting in the ur	nderlying ca	ause give	n in Part	l.			,	to the cause of d	
ed	Pseudomembra	ne Colitis						1 🗆	Yes 2	No 3□F	Probably 4 □U	Jnknown
plet	Urinary Tract	t Infection						24a. Wa		24b. Were a	autopsy findings	available
Completed by	Gastrointest:	inal Bleedir	na					peri	opsy ormed? 2 No	death?		ause or
Be C	25. Was case referred to medical	Indi Diccui.	19			26. Place	e of Deatl	h (Check only		10.0	3 2 110	
To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Xnpatient 2 □	ER/Outpatien	t 3 DO	A Othe	r. 4□ Nı	ursing Ho	me 5□Res	idence 6	□Other (Sp	ecify)	
n:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	21	8c. Injury Work	at		28d. Describe				
oite	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation		iiijaiy	М		′es 2 🗆	No					
ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str	eet, factory	, office			28f. Location	(Street and	d Number or F	Rural Route Num	ber,
ert	*LITOMIOGO	building, etc. (opecin	7/					City of To	wn, State)			
Medical Certification:	29a. Certifier 1 X Certifying Phy	ysician: To the best of my kno	wledge, death	occurred :	at the tim	e, date a	nd place,	and due to the	e cause(s)	and manner a	as stated.	
O	(Check only 2 Medical Exam	iner: On the basis of examina	mon and/or in	contraction	in my or	ab going	ath occur	red at the time	date and	place and du	in to the course/s	• •
ğ	one)	and manner stated.	and and of 117	vestigation,	, 111111y Op	minori, de				praco, and at	e to the cause(s	>)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)
FEB 15 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glenn Jaucian,

M.D. 9450 Penn. Ave. #18 Upper Marlboro, MD. 20772 32. Registrar's Signature

D20824

Feb. 13, 2007

		1 - For State Registrar		State	of Maryla	-	artment rtificate			d Me		iene	07	06294
Physici		1. Decedent's Name (First, MADISON HA			Œ						Date of Deat Month		2007	3. Time of Death 4:10 PMM
/Medic Examir		4a. Facility Name (If not instit			u <i>mber)</i>		4b. City, To		cation of De				nty of Death	ROT
Funeral		5. Social Security Number <b>056–10–2282</b>	6. Se		7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months I	Year If	Under 24 F	Irs. 8.	Date of Birth (Month, Day, AY 20,	Year)10	9. Birthp	lace (State or Foreigr
Director		Usual Residence of Deceden								ri.	A1 20,	1910		
ith the Marylan or 28a-f show	or	MD 10b. Co	inty <b>ALBOT</b>		10c. C	City, Town or Lo EASTON							1	0d. Inside City Limits  1 Yes X No
r 28a-f	Director	10e. Street and Number					10f. Zip C	ode			1	0g. Citizen	of What Coun	
th with	ai Di	8591 NORTH BI	END R	OAD				21601					USA	
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28s-f show event, it a Madical Examinar must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2   3 □ Widowed 4 □ Divo		Armed F	2 XNo Sive		Was Deceder f Yes, specify 1 ☐ Yes 2	Cuban, N	nic Origin? Nexican, Pu <i>pecify:</i>	(Specification (Speci	y Yes or No- an, etc.)		Race - Americ Black, White, cify: WHI	etc.
2 hour		15. Dece	dent's Edu	ication		16a. Deced	dent's Usual	Occupation	n			16b. Kind of	Business/înc	
vithin 7 ne. han "r	Completed	(Specify only his			(1-4or 5+)	life. I	kind of work DO NOT use	retired)		working				
filed w Hygie other th	a)	17. Father's Name (First, Mid		J1		INVES	STMENT			Name (F	irst, Middle, M	BANK Maiden Sum		
2 should be filed within and Mental Hygiene. is marked other than reumetic event, It a M.	To B	ROBERT OTTWA	AY HA	YTHE					ETHE	L T	HORNE			
2 6 8 9		19a. Informant's Name/Relat			'D						loute Number			
of Health item 27		LAURA EDDY/S'.  20a. Method of Disposition	LEP-D	AUGILE		Place of Dispo	sition (Name	of	TE DE	Date			n - City or To	21601 wn, State
Pages nent of int: If it		1 ☐ Burial 2 ▼Cremat 1 ☐ Donation 5 ☐ Other			n State CF	cemetery, cren IESAPEAR	,		N CTR	2/				
permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Sen	vice Licens		CCEIZO	22 FI	Name and	Address of	Facility	IN 8		M FUN	IERAL B	IOME PA
Physician /Medical		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only o	lications that	caused the dea		er the mode		uch as card					Approximate Interval Between Onset and Death 4 4
icate be executed by physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. — Due to	o (or as a conse	equence of):								
o the Hospitei or Attending Physicien: The law requires that the death certificath 24 hours after death.  ithin 24 hours after death.  of the Funerel Director: After this certificate has been signed by the attending pompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:	1 Live	utcome of pregion of pregions of the pregion of the	tal death 3 🗆	Ectopic preg Other (spec						Date of delive Month	ry Day Year
quires that n signed b	by	Part II. Other significant con	ditions co	ntributing to	geath but not re	esulting in the ur	nderlying cau	se given ir	Part I.	_		acco use co		e cause of death? ably 4 donknown
The law re- ite has bee	Completed									_	24a. Was ar autops perform	/	b. Were autor prior to con death? 1 \( \subseteq Yes	osy findings available npletion of cause of
cien: ertifica actor, p	BeC	25. Was case referred to me examiner?	-						. Place of E	Death (C	heck only on			
tending Physicien: The lavileath. Ioath. tor: After this certificate has the funeral director, page 2	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pe		28a. Date	Inpatient 2[ e of Injury onth, Day Year)	28b. Time of Injury		. Injury at Work?	4 12 Nursing		5 Reside			")
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Plac build	ce of Injury - At ding, etc. (Spec	home, farm, stre sify)				28f	Location (Sti City or Town	eet and Nui , State)	mber or Rurai	Route Number,
To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifier (Check only one)	ifying Phy ical Exam	ner: On the	ne best of my kr basis of examir inner stated.	nowledge, death nation and/or inv	n occurred at vestigation, in	the time, o	date and pla on, death or	ace, and	I due to the ca at the time, da	use(s) and ite and plac	manner as st	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of ce	rtifier	(2)				icense nu	-				ned (Month, L	
-5-		30. Name and address of per	son who c	omoleted trail	use of death (Ite	эт 23а) (Туре,		425		et.				o & rxz
Sta	ite	31. Date filed (Month, Day, Y			Registrar's Sign	em 23a) (Type,	rwod	או ה	Eu	7:00	~ Pri C	-16.	,	
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			1 - For State Registrar	State of	f Marylar		artment o			ental Hy	giene	2007	06295
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-las	Physici /Medic		Loretta	Hickey	<i>T</i>					Month Februar	у 9 <b>,</b>	2007	12:40 A <sup>M</sup>
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Н	Funeral Director			_M 2⊠F	54		Months Da		Min	8. Date of Birtl (Month, Day Dec. 13	v. Year)	Coun	lace (State or Foreign etry) essee
	D D		Usual Residence of Decedent						1·	Dec. 13	, 175	z Temi	essee
	arylar show dat	<u>-</u>	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
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	ms 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13. V		-	igin? (Spe	cify Yes or No- Rican, etc.)		. Race - Americ	
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2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	dent's Usual Oc kind of work do DO NOT use re	cupation one during mos	st of workir	ng	16b. Kind	of Business/Inc	dustry
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Baltimore, Maryland 21215-0036	2 should be a nand Mental   is marked o raumatic eve	To B	Alberda Russell R	oberts,	Sr.			Go1	die M	loore			
ar	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (Str	eet and Numbe	er or Flura	l Route Numbe	r, City or T	own, State, Zip	Code)
≥,	es 1 and 2 of Health of Item 27 i		Michael Hickey /	Husband						neytown	n, MD	21787	
<u>o</u>	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from S			sition (Name of natory or other		Feb.	9,		tion - City or To	
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<u>a</u>	permit. Page Department Important: II any injury o		21. Signature Funeral Service Licer	see								ot Cody	
6			23a. Part1. Entyr the disease for companies of reart failure, ist only	olications that ca one cause on ea	aused the deat ach line.	th. Do not ent	er the mode of	dying, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (	or as a conseq	quence of):							
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ROX	leath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	aldeath 3□	Ectopic pregna				230	d. Date of delive Month	nry Dav Year
o.	The law requires that the death te has been signed by the atter age 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of o	death 5∟	Other (specify	')				Monny	Day Teal
<u>.</u>	w requires that the di been signed by the should be detached		Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the ur	nderlying cause	given in Part I.		23e. Did to	bacco use	contribute to th	e cause of death?
Vital Hecords,	quires n sign uld be	d by	No 2	ie Ki	40 64						es 2 🗆 1		ably 4 □Unknown
ပ္တ	aw rei	olete								24a. Was a	ın 2	24b. Were autor	psy findings available
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<u>a</u>	sician: The law certificate has l irector, page 2 s	0	25. Was case referred to medical examiner?	_				26. Place	of Death	1 Yes (Check only or		1 ∐ Yes	2 L No
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Ē	ding Ph J. After th funeral		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	1	njury at Vork?	- 1	8d. Describe h	ow injury o	ccurred	
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DIVISION	pital or Atten	Certification:	4 ☐ Homicide determined	Zoe. Place	ng, etc. (Specif	ome, tarm, stro fy)	eet, factory, offi	ce	2	8f. Location (S City or Tow	treet and N n, State)	Number or Rurai	I Route Number,
_	e Hospital or Attending Physician: 24 hours atter death Funeral Director: After this certifice etely filled in by the funeral director;	0	29a. Certifier 1 Certifying Ph	yslcian: To the	best of my kno	owledge, death	occurred at th	e time, date an	nd place, a	and due to the o	ause(s) ar	nd manner as st	ated
	To the Hosp within 24 ho To the Fune completely f	edical	(Check only 2 ☐ Medical Examone)	niner: On the ba and mann	asis of examina	ation and/or in	vestigation, in n	ny opinion, dea	ath occurre	ed at the time, o	date and pl	ace, and due to	the cause(s)
	To the vithing to the To the Comp.	Ĭ	29b. Signature and title of certifier		_			ense number		2	29d. Date s	signed (Month, L	Day, Year)
			Howard La	winfi 2	4.1.		D	1555	2		2	19107	,
(			30. Name and address of person who	7, 14. D.	5-5-5-	S. CR	4722	Stree.	<del>/</del>	Westn	じょ ノブ	er, Mo	1,21157
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 2	007	gistrar's Signa	ature	parte					-	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Month **Physician** 12:20 A FEBRUARY HAROLD CARLYLE HUFFMAN, JR 13, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X**M 2□ F Yrs Director 82 MARCH 26,1924 VIRGINIA 578-20-9187 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 108 MONROE MANOR ROAD 21666 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates 1944–1946 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 SERVICE TECHNICIAN MAJOR APPLIANCES s 1 and 2 should be filed v f Health and Mental Hygie tem 27 is marked other i other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAROLD CARLYLE HUFFMAN, SR DOMMER SLAYTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 MONROE MANOR ROAD, STEVENSVILLE, MARYLAND 21666 DORIS L. HUFFMAN/WIFE item 27 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY 19. Pages 1 50 1 ■ Burial 2 □ Cremation 3 □ Removal from State ة ≃ Important: It any injury o Department 4 Donation 5 Other (Specify) 2007 STEVENSVILLE CEMETERY STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) They cardis **Physician** /Medical Due to (or as a consequence of): Examiner Coronery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a por sequence of) Examiner certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No Ö the 9 Unknown ģ σ. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 Yes 2 No 3 Probably 4 Gonknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No nerform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ToF Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral di 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident fter death Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ś 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one)

1250 shates

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

Name and addre

anges

hamber (21h

29b. Signature

. Registrar's Signature

130

of person who completed cause of death (Item 23a) (Type, Print)

MD

737014

Love Point Rd

Stevensvilly MD

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. Day 13 Margaret Anna Hoen 11:35 P <sup>M</sup> 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11907 Payton Court Bishopville Worcester If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 🗆 M 213-48-7012 59 Sept. 15,1947Worcester Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13503 Holly Lane 21842 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager Book Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Cholewczynski E. Margaret Dorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald C. Hoen 13503 Holly Lane, Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus eart of Cem. 2-19-2007 | Baltimore, Mar 22. Name and Address of Facility The Burbage Funeral Home 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Fund al Service Licensee 1/2 108 William St., Berlin, Md. 21811 rubale 23a. Part1. Ent. the isease or complications that adject the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or it art failure. List only one cause or year in line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etzgitatic Breast Con 14 years Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home of Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) 1 X Natural

1 ☐ Yes 2 ☐ No

030690

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

<u>م</u>

Completed

Be

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine burial-trar attending physician for use as the buria Physician/Medical been signed by the should be detached 2 Completed Be 2 Medical Certification:

The law requires that the death certificate be executed or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii

Division or Vital Records, P.O. Box 68760

BA 15

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

31. Date filed (Month, Day, Year)

M. D. MARTIN 32. Pgistrar's Signature

145 E. Carroll St. 501:350-4

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

	1 - For State Registr	ar	State	e of Mar	yland / [		nent of F cate of		nd Me		jiene 10g. No.	007	06298
Discoloine		s Name (First, Middle	Last)						2.	Date of Dea Month	th Day	Year	3. Time of Death
Physician /Medical	_ D	obert Hill	Hartma	n					F	ebruar	,		1730 <sup>M</sup>
Examine	4a. Fecility N	lame (If not institution,				4b.		r Location of				County of Deatl	n
		oll Hospita			// · · · · · · · · · · · · · · · · · ·	46 4 1 (6)	Westn	inste		5		rroll	10
Funeral Director			6.Sex † <b>∑</b> M 2□	F	'In yrs. last bii	Yrs. Mor		Hours	Min.	Date of Birth (Month, Day			nptace (State or Foreign untry)
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ehow	10a. State	10b. County		1	IOc. City, Tow	n or Location	)						10d. Inside City Limits
8a-f	Maryla	and Car	coll		West	minste	r						1 ☐ Yes 2ŽQŽÑo
vith the Mar or 28a-f el	10e. Street a	and Number 1302 Wood!	land Dr	ivo		10	f. Zip Code 2115	:7		1	-	zen of What Co USA	untry?
• 23e	3 44 14 14 14 16			Decedent Ev	or in II C	13 14/22 5			in 2 (Consider	y Yes or No-		4. Race - Amer	ican Indian
filed within 72 hours after deeth with the Maryland Hygiene.  Whysiene.  Other then "natural, or iteme 23s or 28s-1 show ent. Its Madral Examinational Examination of Complete Completed by Filmars in Director.	3 □ Wide	er Married <b>2©</b> Marri owed 4 □Divorced	Arme	ed Forces? Yes 2XXIVo s, Give or Dates:	₩ III 0.3.	If Yes	specify Cuba	Specity:	Puerto Ric	an, etc.)		Black, White	
72 ho		15. Decedent (Specify only highes	s Education	ited)	16a	Decedent's	Usual Occup	ation during most	of working			nd of Business/I	,
ed within 72 ho ygiene. ner then "netur: t. the Wedler!!	Elementar	ry/Secondary (0-12)	Colle	ge (1-4or 5+)	- 1	life. DO N	OT use retired	d)	<b>y</b>	1	West	ern Mar	ryland
12 should be filed within n and Mental Hygiene. File marked other then reumalic event, ITEM.		Name (First, Middle, I	5+		P	rofess	or	18 Mother	rin Nama /6	First, Middle, i		ollege	
intai H	1		.231)								vialuell .	Sumame)	
should nd Men marke matic		<u>ry Hartman</u> ant's Name/Relationsh	ip (Type, Print	)	198	. Mailing Add	iress (Street	1000000	mi Gui		. City or	Town, State, Z	in Code)
s 1 and 2 should be flies f Health and Mental Hygitem 27 ie marked othe other traumatic event.	Cather	cine Hartma	an '	Wife		35 Kin						D <del>2115</del>	
ges 1 and 2 1 of Health If item 27 i		of Disposition		_	20b. Place o cemete	f Disposition	(Name of	20)	Date	9	20c. Loc	cation - City or 1	Town, State
Pages nent of I int: If its		ial 2 <b>½</b> Cremation nation 5 ☐ Othe <i>r (Sp</i>			Carrol			1	2/12/0	07 1	Hamp	stead.	Maryland
permit. Pages Department of Important: If I eny injury or once.	21. Signatur	e of Funeral Service I	icensee										Chapel, PA
3 9 7 2 8 9		KNX bg	10			412	Washir	igton I	Rd. We	estmin	ster		1157
	shook,	Enter the disease, or or heart failure. List	oniplications to only one cause	hat caused the on each line.							est,		Approximate Interval Between Onset and Death
Physician	disease or o		_ a	U-175	Moin	TEST	MAL	BLE	EPI	Na			1 WEEK
/Medical Examiner			Du	e to (or as a	consequence	of):							
	Sequentially if any, leading	r list conditions, ng to immediate ar Underlying	b	e to (or as a	consequence	of):							
executed on and ial-transit	Cause (Dise that initiated	ase or injury	d										
		death) Last	Du	e to (or as a	consequence	of):							
physicie po physicie puntum physicie	5		d										
ding p			23c If ves	s, outcome of	pregnancy							04 0-4-4-5	
at the death certification at the attending letached for use as bounded for the attending letached for the attending letached for the attending letached for the attending letached for the attending letached let	23b. Was di	ecedent pregnant past 12 months?	1 🗆 L		Fetat death		pic pregnancy or (specify)	1			2	3d. Date of deli- Month	Day Year
by the a	9 □ Ur	s 2 🗆 No iknown		Jnknown			(						
The law requires that the death certificate has been signed by the attending cage 2 should be detached for use as commissed by Physician/Me		r significant conditio	ns contributing	to death but	not resulting i	n the underly	ing cause giv	en in Part I.		23e. Did tot	pacco us	se contribute to	the cause of death?
w require been sig should b							au <sub>k</sub>			1 □ Ye	es 22	No 3□Pro	obably 4 □Unknown
has be										24a. Was a autops		24b. Were aut	opsy findings available ompletion of cause of
The law required that been spage 2 should										perform	ned? No	death?	2 □ No
ician: Th	25. Was cas examine		L1= '2=2				12		of Death (C	Check only on			
Physical this call direction.		No No	Hospitat:	Inpatient Date of Injury			DOA Oth	4 🗆 14013				□Other (Spec	ity)
ding I	1 Natu	ıral 5 🗆 Pending	, (	Month, Day		Time of n <sub>t</sub> ury M	28c. tnjur Wor	yaı k? Yes 2.⊟N		d. Describe ho	ow intury	occurred	
deat deat ctor: y the	2 Acc	cide 6 Could n	ot be	Place of Injury	/ - At home, fa					. Location (St	reet and	Number or Ru	ral Route Number,
tal or Attending Frs after death. el Director: After ed in by the funer.	4 ☐ Hor	nicide determin	t	ouilding, etc.	(Specify)		,,			City or Town	n, State)		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director. Mandical Certification: To Be Completely filled in the funeral director.		Certifying	xaminer: On t	o the best of e the basis of e manner state	xamination an	dor investig	rred at the tir ation, in my o	ne, date and pinion, death	place, and	due to the ca at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
To the within To the comp	29b. Signati	are and little of certifier			/		29c. Licens	-			_	signed (Month	. Day, Year)
WIL		Mal-	CA				DOC	2595	54	-   (	2/	11/07	
19		nd address of person v		use of dea	th (Item 23a)	(Type, Print)	_	120		· WE	1		
45		215/1/20/to	2 C	1990	ANNO	700	DA	WE	RL	WE	Smi	NSTER	MD 2/15-7
State Registrar		d (Month, Day, Year) FEB 1	5 2007	32. Hegistrar's	s Signature								
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			For State Registrar	State of	Maryland / D	epartment o			-	ne	06299
			Decedent's Name (First, Middle)	Last)	· · · · · · · · · · · · · · · · · · ·			2. Date Mont	of Death	Day Year	3. Time of Death
	Physici /Medic	3.4	Frances A. Ha	les				Febr	uary	10, 2007	4:29 A <sup>M</sup>
1	Examin		4a. Facility Name (If not institution,		er)		n, or Location	of Death		4c. County of Dea	ath
			Union Hospita  5. Social Security Number		Age (In yrs. last birth	Elkt		24 Hrs. 8. Date	of Birth	Cecil	rthplace (State or Foreign
г	Funeral Director		222-10-6337	1□M 2 <b>X</b> F		rs. Months Da	ys Hours	Min. (Mon:	th, Day, Ye	ear) C	ountry) Pelaware
***	D		Usual Residence of Decedent		140.00.7						
	arylar show	_	10a. State 10b. County		10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M 28a-f notifie	Director	Delaware New (	Castle	Chri	stiana 10f. Zip Coo	le .		10g.	Citizen of What C	ountry?
	3a or		33 N. Old Bal	timore Pik	2.		702			USA	
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was Decedent If Yes, specify (		rigin? (Specify Yes	or No-	14. Race - Am Black, Wh	
9	after or ite		1 Never Married 2 Marri	ed 1 Tes 2 If Yes, Give	<b>⊠</b> No	1 ☐ Yes 2 💢			J.,	Specify:	
8	s within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Date		Decedent's Usual Oc	cupation		161	o. Kind of Business	White
5	in 72 n "nat ledica	olete	15. Decedent (Specify only highes	t grade completed)		Give kind of work do life. DO NOT use re	one during mo: tired)	st of working	100	7. Kind of Edsiness	or modest y
212	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4		Homemaker				Dwn Home	
b	be filed value Hygie of other event, the	l ag	17. Father's Name (First, Middle,					er's Name (First, N		,	
yla	should be and Mental s marked o umatic eve	၉	Ernest Raymon		100			achel Ann			
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationsh Raymond Hales		1	Mailing Address <i>(Sti</i> 199 OLd E					. ,
e,	Heali Heali tem 2		20a. Method of Disposition		20b. Place of	Disposition (Name o		Date		c. Location - City o	
IIO			1 💢 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		ate	ana Pres.	1	2-15-200	7 C	vristiana	. Delaware
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signatur of Funeral Service	/	protoco						
8	9 9 E 8 9		Jan 4.			122 West	Main.	jones, In Street, N	ewark	DE 197	
		4	Ma. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	used the death. Do no ch line.	ot enter the mode of	dying, such as	s cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Caus Final disease or condition resulting in death)	- a.	cardial In	•					unknown
	Examiner				ras a consequence o onary Arte	•	0				unknown
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (b)	as a consequence o	h:	C				anenown
	cuted nd ransit	Examine	mai initiated events	с							
Ő,	ate be executed only sicial and the burial-transit		resulting in death) Last	Due to (o	r as a consequence o	f):					
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical		d							
9 x	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outco	ome pf pregnancy					23d. Date of de	elivery
Box	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregna	th 2 Fetal death nt at time of death	3 ☐ Ectopic pregn 5 ☐ Other (specifi				Month	Day Year
P.0	that the de ted by the a detached	hys	9 □ Unknown	9∐Unknov	vn						
	res the igned be de	by P	Part II. Other significant condition	ns contributing to dea	th but not resulting in	the underlying cause	given in Part	I. 23e.			to the cause of death?
ord	w requir been si should		COPD						ı		robably 4 Nunknown
Records,	e law has b je 2 sl	Completed						24a.	Was an autopsy performed	prior to	utopsy findings available completion of cause of
a			25. Was case referred to medical				OC Plea	te of Death (Check	Yes 212		
·Vital	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 💢 In	patient 2 ER/Out	patient 3 DOA	Other:	ursing Home 5		e 6 ∏Other (Sp.	ecify)
1 Or	ding Phy n. After thi funeral o		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of		me of 28c.	Injury at Work?			injury occurred	
sior	en or:	atio	2 ☐ Accident investig	ation		М	1 ☐ Yes 2 ☐				
Division	- e - c	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned Zoe. Flace C	f injury - At home, far g, etc. <i>(Specify)</i>	m, street, factory, of	ice		tion (Stree or Town, S		Rural Route Number,
	Hospital		29a. Certifier 1 💢 Certifyin	g Physician: To the b	est of my knowledge.	death occurred at the	ne time, date a	and place, and due	to the caus	se(s) and manner a	is stated.
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical		Examiner: On the bas and manne	sis of examination and						
	To the within 2 To the comple	Me	29b. Signature and tile of certifier	. 0 .	\	29c. Lid	ense number		29d.	Date signed (Mor	oth, Day, Year)
			> Xaelo	lers nis	) ·		D0023.	322		2-15-200	7
_	6		30. Name and address of person				a 2D 1	E06+2:2 11	n 010	001	
		ate	S.S. Sachdev, 31. Date filed (Month, Day, Year)	M.U. 118	North Str	eer, suit	e JD 1	errion, M	V 219	121	
	Regist		FEB 1/5	2007 32/Re	we the	Goode					

			1 - For State Registrar	State of Marylan	-	artment rtificate			nd Menta	l Hygien	/ 1111	7 06300	
E	Physici	an	Decedent's Name (First, Middle, Last)     Torrest Trace (First Middle)	Co					Mor	of Death	ay Yeer	3. Time of Death 7:00 Am	
	/Medic Examin	al	Darriny Lee Harmon,  4a. Fecility Name (If not institution, give st			4b. City, To	own, or	Location of	Feb Death		2007 c. County of Dee		_
	LAGIIIII		32289 Johnson Road			Sali	Lsbu	ry			Wicomi		
	Funeral Director		5. Social Security Number 6. Sex 212–56–1589	7. Age (In yrs. 57	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min. (Moi	of Birth oth, Day, Year 1, 194	9. Bi	rthplece (State or Foreign ountry) MD	
	yland sow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation			_			10d. Inside City Limits	
	e Mari	ctor	MD Wicomico	Sa	lisbur	У						1 ∑Yes 2 □ No	
	3a or 24	i Dire	10e. Street and Number 32289 Johnson Road			10f. Zip C	804			10g. C	itizen of What C USA	ountry?	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked of the than "netural", or tems 23a or 28a-f show sumatic event, the Medical Examinat matter retilled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ ¥es 2 □ No Arm If Yes, Give Year or Dates:	70 Y 2	Was Deceder f Yes, specify		spanic Origin, Mexican, I	n? (Specify Yes Puerto Rican, e	s or No-	14. Race - Am Black, Whi	te, etc.	
21215-0036	thin 72 ho e. an "netur Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	tent's Usual kind of work DO NOT use	done di	uring most o	of working	16b.	Kind of Business	/Industry	
27	iled wi tygien ther th	Co	17. Father's Name (First, Middle, Last)	2		Tru		Driver	s Name (First,	Middle Maide	Produ	ction	_
Maryland	m = 0 5	To Be	Clifford Harmon						phine Co		n Sumame)		
Mary	2 should he and he ma		19a. Informant's Name/Relationship (Type								or Town, State,	Zip Code)	
e,	1 and Health em 27		Cordelia Harmon/wif	20h P	lace of Disno	sition (Name	of.		Salisbur Date		21804 -ocation - City or	Town, State	-
E O	Pages lent of nt: If It		Donation 5 ☐ Other (Specify)	moval from State St	emetery, crem Mary urch Ce	natory or other	er place CLS V	2	/17/2007			Anne, MD	
Baltimore,	permit. Pages 1 and 2 should bu Department of Health and Menta Importent: If Item 27 Is marked eny injury or other treumatic en		21. Signature Frieral Service Licens	400	22 L	Name and	Address	of Facility	Funeral Salisbur	Home		A DE LOCAL	_
i	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	n. Do not ente	er the mode	of dying	, such as ca	ardiac or respira	atory arrest,		Approximate Interval Between Onset and Death  2 YEARS	
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and hage 2 should be detached for use as the buriat-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  d.	Due to (or as a consequence to (or as a consequence)	uence of):	76		v ÉR,	MEDIAS	7/NUM			_
P.O. Box 6	at the death certifics by the attending pt tached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic preg					23d. Date of de Month	livery Day Year	
	uires that signed b	by	Part II. Other significant conditions control	ributing to death but not resu	ulting in the ur	nderlying cau	ise giver	n in Part I.	236	Did tobacco	_/	o lhe cause of death?	
al Records,		Completed								. Was an autopsy performed? Yes 2 2 N	prior to death?	utopsy findings available completion of cause of 2 \( \text{No} \)	
of Vital	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1   Inpatient 2	EB/Outpation	• 3□ DOA			f Death Check		6 ☐Other (Spe		
on of	ding Phys th. : After this s funeral di	tion: To	27. Manuar of Death  1	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury		. Injury : Work?	at es 2 No	28d. Des	cribe how inju		СПУ)	
Division	To the Hospitel or Attending Physicien: within 24 hours after death 7 To the Funerel Director: After this certific, completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, o	office		28f. Loca City	ation (Street a or Town, Stat	nd Number or Ri e)	ural Route Number,	Ī
	Hospil 24 hour Funer ately fills	Medical (	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno- ir: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred al restigation, in	The time	e, date and p nion, death	place, and due occurred at the	to the cause(s	s) and manner as d place, and due	s stated.  to lhe cause(s)	_
	To the within To the comple	Me	29b. Signature and title of certifier			29c. L	License	number		29d. Da	ate signed (Mont	h, Day, Year)	
)	100		Jaux Shop-	MD.		4	386	47		04	2 - 12 - 2	00 7	
1	Post		30. Name and address of person who com				e man	Ri	SAZIS	BURY	(M) 6	71804	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 4 200	32. Pogistrar's Signa									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** M KATHRYN HOTTLE Ε. 02 19 2007 1950 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2**X** F 03/7/1947 Director 59 Shaw, WV 235-72-2134 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director WV New Creek Mineral 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner must once. HC 72 Box 62 U.S.A. 26743 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unknown Velma Wolford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Dixon/ Son 4 Box 185-A Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State Potomac Memorial 4 ☐ Donation 5 ☐ Other (Specify) 02/23/2007 Keyser, WV 22. Name and Address of Facility 21. Signature of Smith Funeral Home 85 S. Main Street, Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause and in e. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Wearo disease or condition resulting in death) /Medical Die to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trai Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 3□ DOA 2 ☐ ER/Outpatient Certification: To this funeral 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month/Day, Year) 29b. Signature and title of certifier 30. Name and ad itss of per on au of death (Item 23a) Type, Print) 0 Mad Shir 10

State Registrar 31. Date filed (Month, I

Year)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ames -lerra 107 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Deeth Examiner Dever seorges Deorges If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Foreign **Funeral** Months Days Hours Min 1 □ M 280 F Yrs. Director Mary Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits PRINCE 1 Yes 2 No Be Completed by Funeral Director MI GEORGE'S FAIRMONT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5911 20143 STREET USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Haalth and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 0 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARO JAMES GAYE EDWINA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWINA MOTHER FAIRMONT HEIGHTS, MD 20143 JAMES STREET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City of Town, Stata Depertment of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-20-2001 CHEVERLY P.G. H.C. 4 □ Donation 5 NOther (Specify) HOSPITAL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3001 HOSPITAL DRIVE 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or a a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner preu or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 11 1Yes 2 740 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics complately filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann J Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D47737 07 temad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNINGS; 3001 HOSPITAL DRIVE; \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 1 2007 Registrar

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State of Maryland / Department of Health and Me	ntal Hygiene	- management
Certificate of Death	Reg No.	

		1 - For State Registrar	State of Ma	ryland /		artment o			nd M		giene Reg. No.	2007	06303
		1. Decedent's Name (First, Middle, Lat	st)							2. Date of Dea		V	3. Time of Death
Physici /Medic		THELMA	С.		JON	ES				Month 02	11	2007	4:26P M
Examin		4a. Facility Name (If not institution, giv-	e street and number)			4b. City, Tov	wn, or Lo	cation of	Death		4c.	County of Death	
		PRINCE GEORGE HOS	PITAL			CHEVE	RLY				PR	INCE GEO	ORGE
Funeral Director		5. Social Security Number 6. S 218-34-7052  Usual Residence of Decedent	TH ONE	(In yrs. last i	birthday) Yrs.	If Under 1 Y Months D		f Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day 02-28-	h /, Year) 1938	9. Birth Cou WASH	place (State or Foreign ntry) INGTON, DC
and w		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
Marylan f show	ō	MD PRINCE G	EORGE	UPPER	MAR	LBORO							1 ∰es 2 No
after death with the Maryla or items 23a or 28a-f shov	Funeral Director	10e. Street and Number				10f. Zip Co	de				10a Citi	zen of What Cou	ntn/?
with a or	<u></u>	14040 NEW ACADIA	LANE #305			20774					_	.S.A.	
eath	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	1		anic Origi	in? (Spe	cify Yes or No-		14. Race - Ameri	can Indian
iter d	'n.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		10.1	f Yes, specify	Cuban, I	Mexican,	Puerto F	cify Yes or No- Rican, etc.)		Black, White,	
irs af	β	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2🕅	No S	Specify:				Specify: BLA	ACK
If it is within 72 hours after death with the Maryland Hygiene. Hygiene Than "naturel", or items 23s or 28s-f show ont, the Maritcal Example or interior collised at	e	15. Decedent's Ed	ducation	16	Sa. Deced	dent's Usual O	ccupatio	on			16b. Kir	nd of Business/In	dustry
nic 7	ple	(Specify only highest gra	de completed) College (1-4or 5+		(Give life. l	kind of work d DO NOT use re	lone duri etired)	ing most (	of workin	og			,
be filed within 72 ho ntal Hygiene. nd other than "natur event, the Medical	Completed	9th	College (1 401 34	'	BUS	DRIVER					GO	VERNMENT	
at,	Bec	17. Father's Name (First, Middle, Last,					18	3. Mother	's Name	(First, Middle,	Maiden	Sumame)	
And by An	ToE	CHARLES BRANDFOR	D JR.				E	ELSIE	DUC	CKETT			
should have	_	19a. Informant's Name/Relationship (										Town, State, Zij	
alth alth 27 to 27		JAMES E. JONES/HU	SBAND	1	.4040	NEW A	CADI	A LA	NE #	305 UP	PER	MARLBORO	,MD 20774
permit. Pages 1 and 2 should be filled within Department of Health and Manial Hygiene. Important: if item 27 is marked other than any injury or other fraumatic event, the Managone.		20a. Method of Disposition		20b. Place	of Dispo	sition (Name o	of r place)	1	Da	ate	20c. Lo	cation - City or To	own, State
Page nt: #		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif				EMETER		0	2-15	-2007	LAN	DOVER, N	ID
mit.		21. Signature of Funeral Service Licer		1	22	2. Name and A	ddress o	of Facility	JB	JENKIN	S FU	NERAL HO	)ME
Deperiment of the periment of		X. D. M.	-hall		74	74 LAN	DOVE	ER RD	LAN	NDOVER,	MD	20785	
		23a. Part 1. Enter the disease, or com	plications that caused to	the death. D	o not ent	er the mode of	f dying, s	such as c	ardiac oi	respiratory ar	rest,	T	Approximate
Physician		shock, or heart failure. Ust only Immediate Cause (Final	Oh 11	1 -	ATIV	E S	205	5/5					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a			2		10					
Examiner			METASTA	TIC	BRI	EAST	CX	FACE	EX				
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	ce of):								
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thet the death certificated by the ettending placed by the ettending placed for use as t	Physiclan/Med	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of		a [	Ectopic pregn					2	23d. Date of deliv	ery
deat deett	icla	in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	4☐ Pregnant at t			Other (specif						Month	Day Year
by th	hys	9 ☐ Unknown	9□ Unknown										
ires thei	ру Р	Part II. Other significant conditions of	ontributing to death bu	t not resulting	g in the ur	nderlying caus	e given i	in Part I.		23e. Did to	bacco u	se contribute to t	he cause of death?
w require been sign										1 🗆 Y	es 2[	□No 3 □ Prot	oably 4 Unknown
awre s be	Completed									24a. Was		24b. Were auto	opsy findings available
The lay te hes age 2	E									autop	med?	death?	mpletion of cause of
vician: The certificate rector, pag	0	25. Was case referred to medical					26	6. Place o	of Death	(Check only or		1 🗆 Yes	2U NO
Attending Physician: The actors and additional the corticle he by the luneral director, page	To B	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 Inpatien	nt 2 ER/	Outpatien	it 3□ DOA	Other					S ☐Other (Special	fvl
e a P C		27. Manner of Death	28a. Date of Injury (Month, Day		Time of		Injury at Work?			8d. Describe h			<i>y</i> /
Fire Bar	atlo	1 Natural 5 Pending 2 Accident investigation		rear/	пјшу	м		s 2 □ N	lo				
Atte	H	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home,	farm, str	eet, factory, of	fice		2	8f. Location (S City or Ton	itreet and	d Number or Rura	al Route Number,
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houn houn		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowled	dge, death	occurred at t	he time,	date and	piace, a	nd due to the	ause(s)	and manner as s	tated.
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettending physiciently filled in by the luneral director, page 2 should be detached for use as the	Medical	one)	niner: On the basis of and manner stat	ed.	ariu/or in				OCCUFFE	io at the time, (	ate and	place, and due t	o the cause(s)
T T Com	Σ	29b. Signature and title of certifier	- 1.	6-0			cense ni				29d. Date	e signed (Month,	Day, Year)
(11)	1	Asise S	4m	ne			060	236	2		2-	12-0	7
Con .		30. Name and address of person who	completed cause of de	ath (Item 23	a) (Type,	Print)			a	1.0.1		12-09	7
26		ABEBE S. MIRU		501 Ala		AL D	₹		CHE	VERLY	MD	2078	15
Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1					,		,	

			1 - For State Registrar	State of Marylar			nt of He te of De			Reg. N	600	7	06304
	Physici /Medio		Decedent's Name (First, Middle, Las     CORA LEE	JOHNSON						1-20	07	еаг	3. Time of Death 8:45 P M
<del>d</del> en.	Examin	er	4a. Facility Name (If not institution, give	street and number)				ocation of Death	ר		tc. County of		1 -
		7.0	3511 25th Place  5. Social Security Number 6. Se	x 7. Age (In yrs.	iast hirthday)		ple H	111S If Under 24 Hrs.	8 Date of		rince		
	Funeral Director		244-58-9504	м ж 67	Yrs.	Months		Hours Min.	8. Date of (Month, O1-29	Day, Yea -194			ice (State or Foreign y) Carolina
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limits
	f sho	ō			Temple		s						1 ☐ Yes 2 No
	the the 28a-	Directo	Maryland Prince Ge	orge 5	Tempre		p Code			10g. 0	Citizen of Wh	at Countr	y?
	3a or		3511 25th Pla	ce			20748				U.S.	Α.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	I.S. 13. \	Nas Dece	dent of Hisp	anic Origin? (S Mexican, Puert	pecify Yes or	No-	14. Race -		n Indian,
30	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, Ire Medical Evantial most calified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Pes 2 No If Yes, Give Year or Dates:		1 🗌 Yes		Specify:	o moan, etc.)		0 -4	Blac	
3	2 hou		15. Decedent's Ed	ucation	16a. Deced	ient's Usu	ial Occupation	on		16b.	Kind of Busi		
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	l and lealth im 27 her tr		Gloria D. Welling  20a. Method of Disposition				Place	Templ	e Hill Date	-	Location - Ci		in State
Baltimore,	Pages nent of h int: If Ite		n Burial 2 ☐ Cremation 3 ☐	nomoval from State C. 1	Place of Dispo cemetery, crem ar Hil			02-1	9-07		itland	,	
	it. Pa rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	<b>/</b>			nd Address		7 07	Du.	rcrand	, i ici i	y Lana
g B	permit. Page Department of Important: If sny injury or once.		Mary Hedom	an Mo 1374	C	edar	H <u>i</u> 11	FH 4111			uitlan		
-1/2 2/00,			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea one cause on each line.	th. Do not ent	er the mod	de of dying,	such as cardiad	or respirator	y arrest,			Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):			- 1				ス	5
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ROX	eath certifi attending I for use as	J/M	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic p	regnancy				23d. Date		,
Ö.	The law requires that the death certificate be executed tae bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Pes 2 No	4 Pregnant at time of o		Other (s				-	Month		Day Year
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ဥ	e law	nple								utopsy	Dric	re autops or to com oth?	sy findings available pletion of cause of
<u> </u>	cate pag								1 ☐ Ye	s 2 1	No 1 E	Yes 2	No No
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o	ding h. After	to Lon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	28c. Injury a Work? 1 [] Ye	s 2 No			,,		
Division of Vital Records,	Attending Physician: ir death. sctor: After this certifics by the funeral director, t	flca	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factor	y, office		28f. Locatio	n (Street	and Number	or Rural	Route Number,
ă	after t Dire d in b	Certification;	4  Homicide	building, etc. (Speci	ty)				City or	Town, Sta	a <i>t</i> e)		
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exam	ysician: To the best of my knowiner: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred vestigation	at the time, n, in my opin	, date and place nion, death occu	and due to t irred at the tin	he cause ne, date a	(s) and mann and place, and	er as sta d due to t	ted. he cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29	c. License n	number		29d. C	Date signed (	Month, D.	ay, Year)
)			> CLA	11-0		100	Mhai	11.nn =	67	E	Louis	ie a d i i	2 2005
	4114		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	Dec	WUV D		166	DKUH	Eyl	c, 2001
	(10)		Mahrukh Hu	ISSUIN ME	) /.	221	MER	CANFIL	ELAN	5 hi	ANDONE	1CL	2,2007 13c Floo
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								
20	Regist	rar	FEB 16 2001 Lan	un & Spen	and the same of th								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | 1 - For State Registrat Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:45 PM ACKSON OMPE reb 2007 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hall Veternus tall, Ma Charlotte Home Charlotte If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month Days 9. Birthplace (State or Foreign SF MARY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10 M 2□F 250-28-5129 85 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 1 Yes 2 □ No MARYland harlotte 10g. Citizen of What Country 10f. Zip Code United 20622 hanlotte 14911 Load 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kosabel Jacksons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20th Place, Temple Hills, 3912 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Suittand, Md WASHINGTON NationAc Cometery 2/20/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee P Name and The sed Eaching Homes boro t STVIlle, MD 20747 5538 MARL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dusphagia Hspiration urrent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia Due to (or as a consequence of) heart disease pertensive IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown topenia troesophagea 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy schemic 2 🗹 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural

/Medical Examiner Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed Box 68760. Completed by Physician/Medical ettending | P.O. signed by the eld be detached Division of Vital Records, hes To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica Be ပ Certification: filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.

Baltimore, Maryland 21215-0036

f Heelth and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f ahov other traumatic avant, the Madical Examinar must be nutited at

permit. Pages 1 Depertment of H Important: If Ita any Injury or ot once.

**Physician** 

Be Completed by Funeral Director

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5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

and manner stated.

anno

cause of death (Item 23a) (Type, Print)

State Registrar (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

		1 - State Registrar Amend#9. Perr FF	PGC 2-15-0	aryland / Dep 7 <del>cr C</del> é	ertificate of		F	Reg. No.	0.6306
Physici		Decedent's Name (First, Middle, Las     Donna	, Jenkin	S			2. Date of Dea Month Feb.12	Day Year	
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D		4c. County of Dea	
	ું .	National Luth	eran Ho	me	Roc	kville		Montgo	omery
Funeral Director		10 0010	7. Ag	ge (In yrs. last birthda) 85 Yrs.	Months Days		Hrs. 8. Date of Birth Min. (Month, Day Sept. 19	(, Year)	rthplace <i>(State or Foreign</i> country) Michigan ichigan
and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
Mary I sh	ţ	Md. Montgo	mery	Ro	ckville	2			1∭Yes 2 No
or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
23a (23a (23a (23a (23a (23a (23a (23a (	Ta	9809 Veirs D	rive #3			20850		USA	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Mental Hygiene. I feel them 21 is marked other then "natural; or items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ፟፟ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1  Yes  If Yes, Give Year or Dates:	Ever in U.S. 13 No	. Was Decedent of If Yes, specify Cu		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
72 hou	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dec	edent's Usual Occu	ipation	working	16b. Kind of Busines	s/Industry
within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work don DO NOT use retir	ed)			
Hygier Hygier Sther th	ပိ	12			lerk	10 Matheda			State Gov
ould be fill Mental H arked otl	Be	17. Father's Name (First, Middle, Last)  Donald Crai	a				Name (First, Middle, ma Young		
should and Men is marks sumatic	ပ္	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	ling Address (Stree			r, City or Town, State.	Zip Code)
and 2 lealth a m 27 is her treu		Earl Jenkins -	Husband	980	9 Veirs	Dr.,	Rockvill	e,Md.208	50
0 0		20a. Method of Disposition  1 Burial Cremation 3 4 Donation 5 Other (Specify	Removal Irom State )	20b. Place of Disposemetery, cr	position (Name of ematory or other pl itan Cr	emator	Date y-2/13/0	20c. Location - City o	rTown,State dria,Va.
permit. Pag Department Importent: f any injury o		21. Signature of Funeral Service Licen	500 M.A.A		22. Name and Add Hyson	ess of Facility	Inc. 222	2-Wiscon	sin Ave.,
Attending Physicien: The law requires that the death certificate be executed X X relation.  I cleath.  Sector: After this certificate has been signed by the attending physicien and property the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	23a. Part1. Enter the disease, or compshock, or heart lailure. List doll of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. S'e  Due to (or as  b. Ull  Due to (or as  c.	a consequence of):	ct in (			est,	Approximate Interval Between Onset and Death  Webla  Zweks
that the death certificated by the attending pridetached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of do Month	elivery Day Year
w requires that been signed t should be deta	à	Part II. Other significant conditions of		but not resulting in the	underlying cause g	iven in Part I.		bacco use contribute es 2.⊠No 3F	to the cause of death?  Probably 4 □Unknown
icien: The law re certificate has be rector, pace 2 sho	Completed	Dementia Diabetes					24a. Was a autop perfor	sy prior to med? death?	
ntifica tor, p	a	25. Was case referred to medical		and the second		26. Place of	Death Check only or		5 2 140
ding Physicien: The h. After this certificate h. funeral director, pace	ion; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 November 1 Sylvatural 5 Pending 2 Accident investigation	28a. Date of Injui	ient 2 ER/Outpati ury 28b. Time ay Year) Injury	of 28c. In			ence 6 Other (Sp ow injury occurred	ecify)
To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fi	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ijury - At home, larm, s tc. <i>(Specify)</i>			28f. Location (S City or Tow	itreet and Number or F n, State)	Rural Route Number,
To the Hospital or within 24 hours afte To the Funerel Director completely filled in In	edical (			of examination and/or				duse(s) and manner s date and place, and du	
To th To th compl	Me	29b. Signature and title of certifier			29c. Licer	nse number	1	29d. Date signed (Mor	
		Lumuld	mole	~ Mp	000	50612	î	February 1.	2, 2007
4)		30. Name and address of person who of Samuel Ma			Print)			e,Md.2085	
Sta	ate rar	31. Date filed (Month, Day, Year) FEB 15 2007	32. Regist	frar's Signature	27				

		1	For State Registrar	State of M	laryland /	Depa	artment of H	ealth and Death		eg. No.	1 00001
. Se	<b>D</b>		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dear Month		3. Time of Death
7	Physicia /Medic	al	Howard	Ρ.		anz			Februar		007   3:00 a <sup>™</sup>
-	Examin	. 3	4a. Facility Name (If not institution				4b. City, Town, or			4c. County of	altimore
70		. A.	Charlestown Ret		.Lage ge (In yrs. last	hirthday	If Under 1 Year	onsvil			
17.5	Funeral Director		5. Social Security Number 084–09–7152	1. M 2 ☐ F	92	Yrs.	Months Days	Hours M		Year)	9. Birthplace (State or Foreign Country) New York
	*		Usual Residence of Decedent						1000	, , , , , ,	
	a-f show	ctor	Maryland Balt	timore	10c. City, T	own or Lo	cation Cat	onsvil			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28 salbe not	ai Director	10e. Street and Number 719 Maiden Choi	ice Lane HF	R543		10f. Zip Code 21	1228	1	0g. Citizen of Wh	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show important: if itam 27 is marked other than "natural", or items 23a or 28a-f show yinjury or other traumatic event, the Medical Expiration invalibed and once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	i? ≹No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2XXIII	spanic Origin? n, Mexican, Pu Specity:	(Specify Yes or No- lerto Rican, etc.)		- American Indian, White, etc. White
21215-0036	within 72 ho ane. than *natur	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	ot's Education st grade completed)  College (1-4ot		lite.	dent's Usual Occupa kind of work done of DO NOT use retired luction Ma	)	working	Annapol	iness/Industry is Yacht Yard
Maryland 2	uld be filled fental Hygir rkad other fic event, L	To Be Co	17. Father's Name (First, Middle, Peter Janz						Name (First, Middle, a Wolfe	Maiden Sumame,	)
	aith and M		19a. Informant's Name/Relations Nelson Janz/son						Pasadena,		
Baltimore,	Pages 1 a nent of Her int: If itam iry or othe		20a. Method of Disposition 1   Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cem	<sub>etery, cres</sub> crest	osition (Name of matory or other place Mem. Gal	rdens 2	/16/2007	Annapol:	ity or Town, State is, Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee / L	Un				ohn M. Tay ester St.,		eral Home lis, MD 21401
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aPNE	ed the death. I	M		g, such as card	diac or respiratory ari	rest,	Approximate Interval Between Onset and Death
8760,	ate be executed thysicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that infiltated events resulting in death) Last	<b>1</b> c	as a consequer		J				DAYS
O. Box 68	The law requires that the death certificat ite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	ath 3[	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mont	of delivery th Day Year
rds, P.O.	quires that I n signed by Ild be deta	þ	Part II. Other significant conditi	ions contributing to death	but not resulti	ng in the u	ınderlying cause gıv	en in Part I.			oute to the cause of death?
Vital Records,		Completed	,						24a. Was autop perfor	sy pr med? de	ere autopsy findings available for to completion of cause of bath?
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				0#		Death (Check only o	ne)	
of/	di S	ဥ	1 Yes 2 No	Hospital: 1 🗌 Inpa		NOutpatie		4 Nursir	g Home 5 Resid	lence 6 Other	
	ling After fune	lon	27. Manner of Death 1 Statural 5 □ Pendi		Day Year)	injury	Wor	k? Yes 2∐No	20d. Describe i	iow injury occurre	u
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 □ Could	minor 286. Place of	Injury - At home etc. (Specity)	e, farm, st	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
]	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical Co	29a. Certifier 1 Certifyii (Check only 2 Medical one) 1 Certifyii	ing Physician: To the be il Examinar: On the basis and manner	of examinatio	edge, dea n and/or ir	th occurred at the tir nvestigation, in my o	me, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
	To the within To the Complex	Me	29b. Signature and title of certifie	er /	nn		29c. Licens	se number	7 F	29d. Date signed	(Month, Day, Year) Ruf 12 2007
_	7		30. Name and address of person	who completed cause of	of death (Item 2	3a) (Type	1-0 0	G	ROAD	2122	8 mo
	St Regist	ate rar	31. Date filed (Month, Day, Year FEB 1	32. segi	strar's Signatur	re K	book				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6219 AM **Physician** 2 /Medical 4a. Fability Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 HOSPITAL Prin Ce eorge 70 VD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2014 Yrs. NONE 07 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State in than "natural", or items 23a or 28a-1 show the Madical Examinar must be notified at 1 Yes 2 No Crofton Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number # 100 2111 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 ary or other traumatic event, the Madical Examinar mast 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 ☐ Divorced ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None-I NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darrer Kones 1-00 ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1609 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 Donation 5 Dother (Specify) Release to Hospite! 21. Signature of Funeral Service Licensee Address of Facility HUSPITAL DRIVE 23a. Part. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks xtreme prema minutes Physician /Medical Due to (or as a consequence of): Examiner Dreterm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 X No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No 1 ☐ Yes 2 No if or Attending Physician: after death. I Director: After this certifice 26. Place of Death Check only one 25. Was case referred to medical examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Contriving Physician: To the best of my knowledge ideath contract at the time idea and blace and due to the nature(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

filled in by the To the Hospital o within 24 hours af To the Funeral D

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 056536 Du l , and ne 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

MOEG BYLLIGHE, PRINCE GEORGE'S HOSPICENTER, 3001 HOSPDR. 2. Registrar's Signature 31. Date filed (Month, Day, Year)

0

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only one)

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.	
	State of Manyland / Donartment of He	alth and Montal Llusiana	

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Day February 11, 2007 Medical Examiner 0256 hrs KAMARA ALUSINE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** ForeigrSierraLeone Months Days Min Hours Director 26 07-25-1980 214-41-7370 1 XM 2 Usual Residence of Decedent any 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. Count show 1 X Yes 2 No MONTGOMERY SILVER SPRING MD death with the Maryland Director s 23a or 28a-f e notified at o 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 812 EAST FRANKLIN AVENUE 20901 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. must be "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 2 X No Yes BLACK Specify 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. other than the Medical 21215-0036 12th TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Be traumatic event, CATHERINE T. GEORGE ABU B. KAMARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ω 812 EAST FRANKLIN AVE SILVER SPRING, MD 20901 ABU B. KAMARA/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State matory or other place) OLIVET CEMETERY 02-24-2007 WASHINGTON, DC Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER Rd Landover, MD 20785 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a Part I. Enter the disease **Physician** failure. List only one ca use on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Fetal death use as past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been si 2 should b 24b Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? page 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical of Vital æ Hospital: 1 Other<sub>4</sub> Nursing Home 5 2 FR/Outpatient 3 DOA Residence 6 Other Inpatient this 1 🗸 Yes ၉ No 28d. Describe how injury occurred 28a. Date of Injury 8c. Injury at Work' 27. Manner of Death 28b. Time of Injury Feb 11, 2007 Certification: Subject shot 0222 hrs Natural Yes 2 V No Division 5 Pending death To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)
Rear block 1800 West Baltimore Street, Baltimore, MD determined (Specify) Alley 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 11, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, FFR 16 2007 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard I. Kilroy, Sr. February 10 2007 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13300 Wicklow Place Clarksville Howard 8. Date of Birth (Month, Day, Year) July 31, 1 5. Social Security Number 6. Sex № M 2□F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 79 220 16 2722 Director 1927 Maryland Usual Residence of Decedent 1 and 2 should be filled within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location id other than "natural", or itams 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13300 Wicklow Place 21029 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Xes 2 No If Yes, Give Year or Dates: 1945 –48 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Union President Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Michael Kilroy Mary Schultheis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -00 Cassie Kilroy Thompson/daughter 13310 Wicklow Place Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Louis Cemetery 2-15-2007 Clarksville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee - Wyth 1044 Collins Slem | 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Year Day 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Renal Failure, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed 1 Yes 2 XNo 1 🗌 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 XNo After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 29a. Certifier t 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D MD D36252 Feb. 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven T. Kariya 11501 Georgia Ave #515 Wheaton, MD 20902 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State FEB 1 5 2007 Registrar

			For State	State o	of Marylar	•		of Health of Deatl		lental H	ygiene Reg. No.	007	06311
			Registrar  1. Decedent's Name (First, Midd	le, Last)			- Intouto			2. Date of E	Death		3. Time of Death
	Physicia /Medic		Marv		Kram	er				Month 02	Day 1.3	Year 07	2235 M
	Examin	100	4a. Facility Name (If not institution	n, give street and nu			4b. City, Tov	vn, or Location	n of Death			unty of Death	
	** ***		WMHS-Braddock				Cumbe	rland	ar 24 Ura	T 0 Date ( )		egany	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs.			ays Hours	er 24 Hrs. Min.	8. Date of B	Day, Year) 1935	Cour	
Star	Director		170–26–1420 Usual Residence of Decedent		/	1				OCL. C	1933	Penn	sylvania
	yland now at	Ì	10a. State 10b. Count	/	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	e Mar la-f st tified	ctor	PA Some	set	So	merset							1 X Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Co	de			10g. Citizer	of What Cour	ntry?
	s 23a nust i	eral	145 David Lane	12 Was Dos	edent Ever in U	le   12 l	1550]		Origin? (Sn	ecify Ves or N	USA 10. 14.	Race - Americ	ean Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Ma  3 ☐ Widowed 4 ☐ Divorce	Armed F rried 1 ☐ Yes If Yes. G	orces? 2 <b>⊠</b> No ive		f Yes, specify  1 ☐ Yes 2 🔀			ecify Yes or N Rican, etc.)		Black, White,	
21215-0036	2 hou atura cal E	Completed by	15. Decede	nt's Education		16a. Deced	dent's Usual C	ccupation	ant of work	rina		of Business/In	
215	thin 7; e. an "n Medi	ple	(Specify only high Elementary/Secondary (0-12)	est grade completed, College	(1-4or 5+)	- life. L	DO NOT use r	etired)	ost of work	ang	Coun	-	
	ed wit ygien yer th	Con	12			Manag	ger	10.84-1	b l- N/	. (5)		ernment	<u> </u>
Maryland	be fill ad oth even	Be	17. Father's Name (First, Middle William Gross	, Last)						e (First, Midd. Kramer	le, Maiden Su •	rname)	
ryla	hould d Mer narke natic	T <sub>o</sub>	19a. Informant's Name/Relation	shin (Tyne Print)		19h Mailir	n Address (S					own, State, Zip	Code)
Ma	d 2 s th an th an traur		Robin Sweitzer				,				burg,		532
	f Heal f Heal fem 2		20a. Method of Disposition	<u> </u>	20b.	Place of Dispo cemetery, crer				Date	<del>-</del>	ion - City or To	
OE I	Pages lent of nt: if i		1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (		i State I				y Feb	. 19,2	2007 Da	viđsvi	lle, PA
Baltimore,	permit. Departrr importa any inju		21. Signature of Funeral Service	e Licensoe	mai	- 4 -				ewman E sville		Homes 21536	, P.A.
30			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	caused the dea	th. Do not ent	er the mode o	f dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Only one cause on	u.E. w	yocar	Die	intere	tion			6	Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse	querice of):							
3	Examiner		Sequentially list conditions,	b									
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):							
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conse	quence of):					<u>-</u>		
68760,	ficate be executed physician and is the burial-transit	dical		d									
687	ificate g phy as the			0.									
Вох	death certifis e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregr birth 2 □ Fet		∃Ectopic preg	nancv			230	. Date of deliv	
	0 00 0	sicia	in the past 12 months? 1 ☐ Yes 2 【 No		nant at time of		Other (speci					Month	Day Year
P 0	requires that the leen signed by th hould be detache	Phy	9 ☐ Unknown  Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying caus	e given in Par	rt I	23e Dio	tohacco use	contribute to t	he cause of death?
ds,	w requires that s been signed t s should be dete	by		encepho	4 10	Sulling III line u	naenymg caac	o givoiriir a			Yes 2		
Ö	requ been should	etec	- CVWAIC	Or ocpre	(0)27	5				24a. Wa			ppsy findings available
Records,	ha:	Completed								au pe	topsy rformed?	prior to co death?	mpletion of cause of
Vital	i <b>clan:</b> Th certificate ector, pag	ပ္ပိ	25. Was case referred to medic	al				26 Pla	ace of Deat	1 Yes		1 ☐ Yes	2 No
>	Physician: r this certific ral director,	0 8	examiner? 1 ☐ Yes 2 No	Uppnitol: B	Inpatient 2	] ER/Outpatier	nt 3 DOA	Othor			,	Other (Specia	fy)
וסר	ding Phi h. After thi funeral	Ë.	27. Manner of Death	28a. Date	-	28b. Time o Injury	f 28c	Injury at Work?			e how injury o		
ior	Attending r death. ector: After by the fune	atio	Z L Accident	tigation			М	1 ☐ Yes 2	□No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Hornicide deter	i   200, Flat	ce of injury - At h ding, etc. <i>(Spec</i>	nome, farm, str ify)	reet, factory, o	ffice		28f. Location City or 7	(Street and N own, State)	lumber or Run	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce		ing Physician: To the	basis of examin								
	o the	Med	29b. Signature and title of certif	<del>- (-)</del>	nner stated.		29c. L	icense numbe	er		29d. Date s	igned (Month,	Day, Year)
	F S F ŏ		> Xwa	66 X	Ku		D	8100	216		2/1	5/07	
			30. Name and address of person	n who completed car	use of death (Ite	m 23a) (Type,	Print)		_		-11	5/07	
7,87		25	Steven	R Smi	thumo	909	201	n Dr	Cu	mberl	ark my	215	52
	Sta Regist		31. Date filed (Month, Day, Yea	2007	Registrar's Sign	ature .	call o						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2007 **Physician** Madhav Singh Karki 12:40P M Feb. 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours Voor 1 XM 2 □ F Yrs. 70 Director 190-80-4581 12/30/1936 Nepal Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show 1 □Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director Maryland Prince George Camp Springs 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5151 Allentown Road 20746 Nepal Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 □Yes 2X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Indian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) Mental Health Psychologist 12 should be filed w th and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 Is marked any Injury or other traumatic ev Lok Badhur Singh Karki Khem Kumari Singh Karki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reena Karki/ Daughter 10789 Pam Dr. Waldorf, MD. 20605 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from \$tate 2/12/2007 Edgewater, MD. Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signature Funeral Service Licenses alas 6160 Oxon Hill Rd. Oxon Hill, 23a. Part L'Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Systemic Inflammatory Response Syndrome Physician /Medical Due to (or as a consequence of) Examiner Cardiogenic Shock Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed Coronary Artery Disease burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical law requires that the death certificate as the attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Ischemic Stroke 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1□ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No o the Hospital or Attendii ithin 24 hours after death. o the Funeral Director: A ompletely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D62200 2/10/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Rd. M.D. Clinton, MD. 20735 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 15 2007 Registrar

			For State Registrar	State of Marylar		artment of F			giene	The state of the s	06313
	Physici	an	Decedent's Name (First, Middle, La.					2. Date of Dea	ath Day	Vear	Time of Death
	/Medic	al	LILLIAN W. KEELIN  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Do		4c. County		6:40 P M
	Examin	er	FUTURE CARE PINEV			CLINTO		54.II	-	CE GEOR	GES
	Funeral Director		5. Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. B. Date of Birt	1921	9. Birthplace Country) MARYLA	e (State or Foreign
D	3		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d.	Inside City Limits
Marvi	f sh	ğ	MARYLAND PRINCE G		JITLAND						1 XYes 2 No
the d	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	,
th W.	23a c	raiD	5000 LYDIANNA LAN	E		207				STATES	
d 21215-0036 filed within 72 hours after death with the Maryland	ital Hygiene. ed other then "natural", or Itama 23a or 28a-f show avent, it a Medical Examinar must be notified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1Yes 2 \ncap No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Tyes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)		ce - American II ick, White, etc. fy: BLACK	
	nature lical E	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation	working	16b. Kind of B	Business/Industr	ry
21215-0036	hen .	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d) _		HEATT	H CARE	
ם ק	Hygie other t	e Co	10TH GRADE  17. Father's Name (First, Middle, Last,	)	NUN	SE ASSIS		Name (First, Middle,			
Č 0	= 0 5	To Be	JOSEPH WASHINGTON		10h Maili	a Address (Street		E IRENE C			
Z S	th and 17 is n traun		19a. Informant's Name/Relationship ( STANLEY KEELING /					SUITLAND,			
ē,	f Heal Itam other		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location	- City or Town,	State
altimore,	nent o		1 Donation 5 Other (Specification 5 Donation 5 Dother (Specification)	Hemoval from State		APITST CHUI		WARY 17,200	7 GRAY	TON, MA	RYLAND
Balti	Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic at 2008.		21. Signature of Funeral Service (Carlotte LYDIA C. THORN)	OM JOHŃSON MOC	J583   s	3439 I.TVI	NGSTON	HOME, P.	IAN HEA	D, MARY	(LAND_2064
		~~	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory ar	rest,	Inte	proximate erval Between aset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. NONHODGKIN'S	S LYMPH	IOMA					Joi and Doam
	/Medical xaminer		Todaling in doziny	Due to (or as a consec	quence of):						
		le.	Sequentially list conditions,	b. Due to (or as a sunsec	quenes of):						
patrio	nd	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
760,	ysicien and he burial-transit		resulting in death) Last	Due to (or as a consec	quence of):						
876	physic s the b	dicai		_ d.							
Records, P.O. Box 68760,	attending p	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy				23d. Da	ate of delivery	
P.O. Box	d for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	/ 		1	onth Day	y Year
0	by the a	hys	9 Unknown	9□ Unknown							
S S	igned b	þ	Part II. Other significant conditions	ontributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.		obacco use con		
ord	been si	eted	SEVERE ANEMIA					-			y 4 Unknown
Records,	hes t	Completed	STROKE					24a. Was autop		Were autopsy prior to comple death?	findings available etion of cause of
	ificete or, pa	ပို	25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only o		1 ☐ Yes 2 ☐	] No
	is cert direct	0 8	examiner? 1 ☐ Yes 2 🗓 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott		g Home 5 ☐ Resid		her (Specify)	
vision of Vita	ter th	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				now injury occur		
Sio	leath. tor: A the fu	catic	2 ☐ Accident investigatio				Yes 2 □ No	1001			
	9 = -	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, tarm, st ify)	reet, factory, office		City or Tox	Street and Numi vn. State)	or Hurai Ho	sute Number,
ם אַ	within 24 hours of To the Funeral D completely filled is		29a. Certifier 1 X Certifying Pt	hysician: To the best of my kn	owledge, deat	h occurred at the ti	me, date and pla	ace, and due to the	cause(s) and m	anner as stated	d.
1	n 24 h	Medical	(Check only 2 Medical Examone)	miner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	opinion, death o	ccurred at the time,	date and place,	and due to the	cause(s)
Š	within To #	×	29b. Signature and title of certifier			29c. Licens		i i	29d. Date signe		
}			191///VQ	D		D 51	.520		FEBRUAR	Y 13, 2	2007
7	R3		30. Name and address of person who BAHRAM PISHDAD,	M D 1220 COIT	THE TALL A	VENUE #	310 WACI	אוואנדוטא זא כ	2003	2	
Y	Sta	ate	31. Date filed (Month Day Year) 4	2007 32. P Sistrar's Sign	ature	1 10 m	JIU, MILI	LINICATO DOC	. 2003.		
	Regist		LER 14	LUU NORME	10 1	pare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** F. ELIZABETH KREVIS 3:26 AM February 22. 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/1/1927 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
NEW JERSEY **Funeral** 1□ M 2/(XF Days Hours 79 Director 143-20-2369 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Int. If item 27 Is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits FRANKLIN Director STATE LINE 1 ☐ Yes 2 Y☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15600 OAK TREE DRIVE 17263 USA Be Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify. WHITE 3 Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry OWN HOME Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE STRYCHARZ EDWARD MIKOS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL KREVIS/SON 15600 OAK TREE DRIVE, STATE LINE, PA 17263 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once, SMITHSBURG CREMATORY SMITHSBURG, MD 23, 2007 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service Licensee les' 327 W. KING ST., MARTINSBURG, WV 25402 m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months2 Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kensel 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1□ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 10 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Depatient 2 ER/Outpatient 3 □ DOA 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Utamiral 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 251 E. Anhetam Street. Hagerstow, MBAOUA, MU JUDITH

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

egistrar's Signature

		•	For State Registrar	State of I	Maryland /		artment <i>rtificate</i>					giene Reg. No.:	07	06315
			1. Decedent's Name (First, Midd	lie, Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Ola V	irginia Lin	ie						Febru	ary 15	2007	12:12PM <sup>M</sup>
	Examin		4a. Facility Name (If not institution	on, give street and numb	er)		4b. City, 1	Town, or	Location of	of Death		4c. Cou	nty of Death	
			1106 South P				If Under		gerst		0. Date of Bird			County
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last 100	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da May 6	y, Year)	Cour	
	Director		230-01-6034 Usual Residence of Decedent		100						May 6	1900		rginia
	yland		10a. State 10b. County	4	10c. City, To	own or Lo	cation						1	10d. Inside City Limits
	a-f s	cto	Maryland Was	hington	]	Hagei	stown	1						14 Yes 2 No
	or 28	Director	10e. Street and Number	D-1 Ct			10f. Zip		21740			10g. Citizen	of What Coul	•
	ath w			Potomac Str					21740		- 4 - V N	14.0	Race - Americ	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumatic event, the Masical Examires mart be rottlied at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Ma  3 ☒Widowed 4 ☐ Divorce	If Vac Give	as? ⊠No		was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White, ecify: Whi	etc.
Š	72 ho	Completed	15. Decede	nt's Education est grade completed)	1		dent's Usua kind of wor			t of work	ina	16b. Kind o	f Business/In	dustry
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anc	ntal h	Be	George W. Ar						TO. WOUN		organna			entrout
چ	should od Me mark matic	၉	19a. Informant's Name/Relation		- 1.	19b. Mailir	ng Address	(Street a	and Numbe		al Route Numb			
<u>s</u>	and 2 state at trau		Rosetta Davi	.s (daughte	er)	148	Will	owda	ale D	r.	Frederi	ck Mar	yland	21702
ē,	s 1 au if Hea if Hea oths		20a. Method of Disposition		ceme	of Dispo	sition (Nam	ne of ther place	e)		Date	20c. Location	on - City or To	own, State
Ë	Page nent o int: If		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		319	-	ll Cem		. 1	Feb	20 2007	Hage	rstowr	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic as <u>once</u> .		21. Signature of Funeral Service	e Licensee							_		_	eral Home
<u> </u>	\$9E # 9		Dungles,	N. Hur	4							· -	Maryl	and 21742
П		Í	23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that cause only one cause on each	sed the death. [ h line.	Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
j	Physician		Immediate Cause (Final disease or condition resulting in death)	a CGA	18 40 VAJ	CULI	12	ACC	1000	7				3 4335N
	/Medical Examiner		rosulting in douting	Due to (or	as a consequen	ce of):								
		e.	Sequentially list conditions,	b. Oue to (or	35 3 00/50010/	ea of):								140000
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9	eath certific attending p I for use as I	Med	IF FEMALE:	23c. If yes, outco	mo of pregnance							20.4	Data of data	
Box	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 Fetal de	ath 3[	Ectopic pr					230.	Date of deliv Month	Day Year
P.O.	that the de ned by the a detached t	ysto	1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	9☐ Unknow			J 011101 (3p							
	s that	by Ph	Part II. Other significant condit	tions contributing to dea	th but not resultir	ng in the u	nderlying c	ause give	en in Part	l.	23e. Did t	obacco use o	contribute to t	he cause of death?
rds	w requires been sign should be	pa pa	NONE								10	Yes 2 ☑N	o 3 ☐ Prol	bably 4 Unknown
Division of Vital Records,	law requ as been 2 shoule	Completed									24a. Was	an 24	4b. Were auto	opsy findings available ompletion of cause of
Ě	The lay ate has page 2	E O									perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	
/ita	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medic examiner?								h (Check only			
<u>}</u>	Physician: The lithis certificate har al director, page	၉	1 Yes 2 No		patient 2 ER						me 5 Hesi 28d. Describe			fy)
u C	ding F h. After funer	ion ion	27. Manner	28a. Date of (Month, stigation	Day Year)	lb. Time o Injury	M	8c. Injun Work	γαι ∢? Yes 2□		280. Describe	now injury oc	Carred	
isi	or Attending after death. Diractor: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place o	f Injury - At home	, farm, st					28f. Location (	Street and N	umber or Rur	al Route Number,
<u>S</u>	after Dira	Certification:	4 Homicide	building	, etc. (Specify)						City or To	wn, State)		
	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C		ring Physician: To the ball Examiner: On the bas and manner	is of examination									
	To th withir To th comp	M	29b. Signature and title of certif	ier			290	. License	e number			29d. Date si	gned (Month,	Day, Year)
)			how Ill	then, my	>		7	000	010	40		02-1	6-200	7
- s			30. Name and address of perso	n who completed cause	of death (Item 23	Ba) (Type,	Print)					en 9/19-	27002	
2	H-5		31. Date filed (Month, Day, Yea	322 (W) 32 R=	istrar's Signature	ピアノ	the s	5	MAGE	1570	IN M	217	40	
	Sta Regist	ate rar	FEB 2	0 2007	A Level	. 1	out	,						
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DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Ma		/ Depa		t of H	ealth a	and M	lental Hy		2007	06316
			Negistrar     Negedent's Name (First, Middle, Last	)				-			2. Date of De.	ath		3. Time of Death
	Physici	an	· · ·	rriett C.	Laze	nbv					Februa	rv 1		10:30A M
	/Medio Examin		4a. Facility Name (If not institution, give		<u> </u>	1201	4b. City,	Town, or	Location	of Death		-	County of Death	
	Examili	E	Elternhaus Assist		Г		Da	yton	1			1	Howard	
	Funeral Director		5. Social Security Number 6. Se 041-20-0915	x 7. Ag	e (In yrs. Ia:	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Nov 17	th y, Year) , 19:	9. Birth Coul 25 Conn	place (State or Foreign htry) ecticut
	pg &		Usuel Residence of Decedent  10a, State 10b, County		10c, City.	Town or Lo	ocation						Τ.	10d. Inside City Limits
	sho	ō	_		01	11	1							1 ☐ Yes 2X No
	28e-1	Director	MD Howard  10e. Street and Number		Clar	ksvil	10f. Zip	Code				10g. Citi	zen of What Cou	ntry?
	with 3a or		13713 Lakeside Dr	ive				2102	29			Un	ited Sta	tes.
	ns 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	. 13.				igin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,	
920	hin 72 hours atter death with the Maryland e. en "natural", or Itams 23a or 28e-f show Medical Examble must be multied at	þ	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ☐ Yes 2001  If Yes, Give  Year or Dates:			1 ☐ Yes :				nican, etc.)		Specify:	ite
9	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece	dent's Usua kind of wor DO NOT us	I Occup	ation during mos	st of work	ing	16b. Ki	ind of Business/In	dustry
21	9 9	nple	Elementary/Secondary (0-12)	College (1-4or	5+)								O II	
2	77 77 17 17	Co	12				Homem	aker		er's Name	e (First, Middle,		Own Home	
Maryland 21215-0036	d la d	To Be	17. Father's Name (First, Middle, Last) Frank Smith						Hilo	da W	isting			
a	and and aum		19a. Informant's Name/Relationship (7										r Town, State, Zip	
2,	s 1 and 2 f Health item 27 l		Melissa Mattey/da	ughter	20b Pla						Clarksv:		MD 210 pocation - City or To	
0	Se to I		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State			matory or o				-2007		icott Ci	
Ë	artmeni ortant: injury		* 4 □ Donation 5 □ Other (Specify				s Cem		-					
Baltimore,	parmit. Page Department of Important: If eny injury of		21. Signature of Funeral Service Licen	With	M0104	4	112 0	ld C	columi	bia I	Pike El	lico	ke's Fam tt City,	ily FH Inc. MD 21043
*	Physician /Medical		23a. Part1. Enter the disease, or composition, or heart failure. List only summediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ardial	list			ig, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
3760,	ate be executed was executed in the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Due to (or as			t fai	luve						
P.O. Box 68	The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3[	⊒Ectopic pi □ Other (sp		′				23d. Date of deliv Month	rery Day Year
	uires that signad by ild ba deta	by	Part II. Other significant conditions o	ontributing to death t	out not resul	ting in the t	underlying o	ause giv	en in Part	l.		tobacco ( Yes 2		the cause of death?
Division of Vital Records,	fhe law raquir le has been si age 2 should	Completed									24a. Was auto perfo		prior to co death?	opsy findings available ompletion of cause of
ta	ician: Th certificate rector, pag	60	25. Was case referred to medical						26. Plac	e of Deat	h (Check only			
$\geq$	ysici is cer direc	ToB	examiner? 1  Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatie	nt 3 DC	OA Oth	ier: ₄□N	ursing Ho	ome 5□Resi	idence	6 XOther (Speci	myasst. livo
0	ding Phys h. After this funeral di	ii.	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time o	of 2	28c. Injur Wor	y at k?		28d. Describe	how inju	ry occurred	
Sion	Attending Physician: ir death. ector: Atter this certifics by the funeral director,	Certification:	2 Accident investigation		iuny - At hor	ne farm si	M treet factor		Yes 2□	No	28f. Location (	Street ar	nd Number or Rur	ral Route Number,
Divi	after after I Direct	ertif	4 Homicide determined	building, e	tc. (Specify)	)	iroot, lactor	y, omoo			City or To	wn, State	9)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examinati	vledge, dea on and/or i	th occurred nvestigation	at the tir	me, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s date and	) and manner as : d place, and due !	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Da	te signed (Month,	
			2 Xabbe to	m m	O.		I D	D5	543-	7		Febr	ruany 13	3,2007
70	2		30. Name and address of person who	completed cause of	death (Item	23a) (Type				4	No.	-	-	
	345		Elizabeth Bower		vming		Way	W	)0092	tock	MD	21	163	
	St Regist	ate	31. Date filed (Month, Day, Year) FFB 1 5	32. P gist	rar's Signa	ure	fra. I	,						
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02Month 14 Pay **Physician** Delores 2007 1915 LOUDERMILK JOYCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🔽 F 69 190-30-2147 April 16 1937 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State 28a-f show la or 28a-f shot t be notified a MD. Allegany Westernport Y⊠Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 218 Greene St. 21562 United States permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner must b once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: white Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ➡ No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erving Pardoe Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 218 Greene St., Westernport, Maryland Gene Loudermilk/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/17/ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Barton, Maryland Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses a 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unwerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page uneral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1/1 Inpatient this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical ( 29a. Certifier (Check only one) completely and manner stated within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 60478 30 Name and address of

State

Registrar

31. Date filed (Month, Day, Year)

FEB

6

625 Kent

Avenue

Cumberland Maryland 21502

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Johnson Heights

			1 - For State Registrar Amend #5,perFD					nd Mental Hy	Loop	007	06318
			1. Decedent's Name (First, Middle, Last)	, 000), 1/20	707 11 00	Timouto of	Douth	2. Date of De	Reg. No. ath		3. Time of Death
*	Physici		Robert James Liber	ty, Sr.				Month Februar	Day	Year 2007	12:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of I			ounty of Deat	
	LAUIIIII		572 Shore Acres Ro	ad			Arnold			Anne A	rundel
	Funeral		Social Security Number     6. Sex		(In yrs. last birthday	If Under 1 Yea Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th v Year)	9. Birti	hplace (State or Foreign
	Director		210-03- <del>0003</del> 0003	M 2□F	85 Yrs.	Wionais Bay	1,02,0	Nov. 22			t Virginia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Aaryla Peho	ō	Maryland Anne Arun				rnold				1 ☐ Yes 2 🛣 No
	28a-	Director	10e. Street and Number			10f. Zip Code			10a. Citize	en of What Co	untry?
	3a or		572 Shore Acres Ro	ad			2101	2		U.S.A	•
	hours after death with the Maryland turel; or Items 23s or 28s-f show al Exaction must be collified at	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or No	- 14	. Race - Ame	
ထ	after or its	Ī	1 ☐ Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2X No		Puèrto Rican, etc.)		Black, White	•
5-0036	urei',	d by	3 Widowed 4 Divorced	Year or Dates:	1942–46	12.03	o opodny.		3	Specify: Wh	ite
Ω.	nati	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	edent's Usual Occu e kind of work don DO NOT use retir	e during most o	of working	16b. Kind	d of Business/	Industry
7	filed within 72 Hygiene. other than "nat ent, it a Medici	m d	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ncipal	60)		Co	unty S	chools
2	filed Hygi other		17. Father's Name (First, Middle, Last)	<u> </u>	***	ICIPAL	18. Mother's	s Name (First, Middle,			
<u>a</u>	should be land Mental I marked o umatic eve	To Be	Walter Allen Liber	ty			Ada 1	Herwig			
Maryland 2121	2 should be filed within 72 hours after death with the Marylan and Manth Hygiens. I and Manth Hygiens is marked other than "naturel; or litems 23a or 28a-1 show aumatic event, it a Medical Exertical mante are collined at		19a. Informant's Name/Relationship (Typ	oe, Print)				or Rural Route Numbe	er, City or T	Town, State, Z	Zip Code)
Σ	and 2 seith an 27 i		Robert Liberty, Jr	./son		Shore Acı	res Road	d Arnold,	Mary	land	21012
altimore,	permit. Pages 1 and 2 should by Depertment of Heelth and Menta Important: If Item 27 is marked any Injury or other traumatic erones.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Disp cemetery, cre	matory or other pl	ace)	Date		ation - City or	
Ē	ment ment: tent:		4 □ Donation 5 □ Other (Specify)	1 00				2/15/2007		_ ,	-
Bail	Deper Mpor Iny In		21. Signatur Funeral Service License	9-W				John M. T cester St.	-		
	40340	Н	23a. Part1. Enter the disease, or compli	accer					•	aports	Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			_				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to /or on o	consequence of):	077411	Cui	Kinoma			17 YVS
	Examiner			Due 10 (01 as a	consequence or,						
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
	The law requires that the death certificate be executed is has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ő,	e execien a	EX	resulting in death) Last	Due to (or as a	consequence of):						
8760	cate b	dicai	d								
ox 6	eath certifii ettending p for use as	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy				22	d. Date of deli	
B	etter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23	Month	Day Year
o.	by the tached	hysi	9 Unknown	9□ Unknown							
w, or	res that igned to be det	by Physician/M	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause g	oven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Records,	v require been sig should b	ed						1 1 `	/es 2	No 3□Pro	obabiy 4 Unknown
ပ္ပ	e law re has be je 2 sh	Completed	A					24a. Was	an	24b. Were au	topsy findings available completion of cause of
_		ĕ							rmed? 2AINo	death?	2 No
Vita	iclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	()		
	Physic this co	2	1 □ Yes 2 ⊠ No	ospital: 1  Inpatient	2 ER/Outpatie	III JUDOA		ing Home 5 Resid			cify)
Division of	ding P. h. After t	ü	27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of Injury (Month, Day )	Year) 28b. Time (	W	ork?	28d. Describe I	now injury o	occurred	
S	Attending Physician: r death. sctor: After this certific by the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of laius	At home form		JYes 2 □No		Stenat and I	Mumba O	10
2	or At after of Direct in by	Certification:	4 Homicide determined	building, etc.	y - At home, farm, si (Specify)	reet, ractory, office	9	City or Tov	vn, State)	vumber or Hu	ral Route Number,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phys	sician: To the best of	my knowledge, dea	th occurred at the	time, date and s	place, and due to the	cause(s) ar	nd manner as	stated.
	he Hc n 24   he Fu cletely	Medical	(Check only 2 Medical Examinations)	ner: On the basis of e and manner state	xamination and/or ii	nvestigation, in my	opinion, death	occurred at the time,	date and pl	ace, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	110 1	11-	29c. Ljoer	se number	20	29d. Date :	signed (Month	n, Day, Year)
			- Jewa	my co			1.107	00		14/1	007
6	311		30. Name and address of person who con	mpleted cause of dea	th (Item 23a) (Type	Print) C	700 L	3 esta ase	RA	Am	napolis, und
	1+1 Sta	to	31. Date filed (Month, Day, Year)	-	s Signatuge	<i>A</i>		7 31	4		2140/
	Registr			007 Deneson		marks.					

			1 - For State Registrar		State of Ma	ryland / Depa <i>Ce</i>		nt of Healt e of Dea			jiene) (	07	063	3   9
	Physici		1. Decedent's Name Viola	(First, Middle, Last May Le						2. Date of Dea Month February	13, 2007	Year	3. Time of 4:05	f Death A M
	/Medi Examir		4a. Facility Name (If r Carroll He					Town, or Locat		<del>-</del>	4c. County	of Oeath		
	Funeral Director		5. Social Security Nur 217-05-5	332		(In yrs. last birthday) 9.4 Yrs.	If Under Months			8. Date of Birth (Month, Day June 2	Year) 5 1912	9. Birthp	lace (State of try) MD	or Foreign
	yland		Usual Residence of D 10a. State	10b. County		10c. City, Town or Lo	cation					1	0d. Inside C	ity Limits
	a-f sh	ctor	MD	Carr	oll	Westm:	inst	er					1 🗆 Yes	2 🔀 No
	with th	Director	10e. Street and Numb				10f. Zip			1	log. Citizen of W	Vhat Coun	itry?	
9	within 72 hours after death with the Maryland ene. than "naturs!", or itsms 23e or 28e-f show the Modical Exhibitor must be notified at	/ Funeral	11. Marital Status	1 2 Marned	Valley R  12. Was Decedent E Amed Forces? 1 □ Yes 2 1 N If Yes, Give	ver in U.S. 13,				ecify Yes or No- Rican, etc.)		k, White,		
21215-0036	hin 72 hours a. nn "natural", Medical Ext	Completed by	3 Widowed 4 (Specify Elementary/Second	5. Decedent's Edu only highest grad	Year or Dates:	16a. Dece (Give	dent's Usu	al Occupation ork done during se retired)		ng	16b. Kind of Bu	Wh:	ite Justry	
21	filed with Hygiene. other ther ent, the N	Соп	8			.,	Owr				Leister		tore	
Maryland	a d a b	Be	17. Father's Name (F		.b o f f					(First, Middle,		e)		
7	should and Men smarks surmatic	2	19a. Informant's Nam	vard Day		19b. Mailii	na Address			V. Lamb		State. Zio	Code)	
	and 2 ; lealth ar m 27 ls		Caroline	Morgan -	- Daughter		-			aster,	•		,	
Baltimore,	ges 1 and 1 of Health If Itsm 27 or other tr		20a. Method of Dispo		Removal from State	20b. Place of Dispo cemetery, crei	natory or	me of other place)	02/16	°°2007	20c. Location -	City or To	wn, State	
<u>ti</u>	Pages tment of h tant: If Its		4 ☐ Donation 5	Other (Specify)		Pleasant		_			leasan			-
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Fund	Wells	7					ts Fune Westmi		e & C	Chapel 157	, P.A
	Physician		23a. P. 11. Enter 1 e shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only o	a. VENTR	ICULTR				· ·	est,		Approximat Interval Bet Onset and I	tween Death
68760,	Medical Medica	edical Examiner	Sequentially list concif any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	_	b. ATHER Due to (or as a	consequence of):  consequence of):  consequence of):	20T1	C H	EART	DIS	ERE		20 y	zam
P.O. Box 68	ath certifications or use a	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	opths?	23c. If yes, outcome of 1 to 1 to 1 to 2 to 2 to 2 to 2 to 2 to	2 ☐ Fetal death 3 ☐	Ectopic p				23d. Date Mor	e of delive		Year
	quires that the de n signed by the a uld be detached t	þ	Part II. Other signific	ant conditions co	ntributing to death bu	t not resulting in the u	nderlying	cause given in P	art I.	23e. Did tol	bacco use contr es 2 1 No		e cause of d ably 4 □t	
Division of Vital Records,		Completed								24a. Was a autops perform	med? d	Vere autor rior to con eath?	psy findings and pletion of care	available ause of
Vita	sicien certifi rector	Be	25. Was case referre examiner?		Hospital:		-50.0	04		(Check only on		Car	roll Ho	· SPiCe
ion of	ng Phy fter this ineral c	atlon: To	1 ☐ Yes 2 ☐ VA 27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier  y 28b. Time o Injury		DA 4 L 28c. Injury at Work? 1 ☐ Yes	2	me 5 Reside 28d. Oescribe ho		or (Specify	DOVE	Houst
Divis	To the Hospital or Attendi within 24 hours efter death. To the Funersi Diractor: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Ptace of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factor	y, office	2	28f. Location (Si City or Town		er or Rura	l Route Num	ber,
	To the Hospital or within 24 hours effer to the Funeral Dir completely filled in I	Medical	29a. Certifier 1. (Check only 2 one)	Certifying Phy Medical Exami	sician: To the best of ner: On the basis of and manner sta	f my knowledge, deatle examination and/or in	n occurred vestigation	at the time, date, in my opinion,	e and place, a death occurre	and due to the ca ed at the time, d	ause(s) and mar ate and place, a	nner as st nd due to	ated. the cause(s	;)
	o ths o ths omple	Med	29b. Signature and til	te of certifier	and manner sta	lou.	290	c. License numb	per	2	9d. Date signed	(Month, I	Day, Year)	
	WIL		*(gli	1 0	de Noef	ama		D18	100		2/131	07		
	W3		30. Name and address	s of person who c	ompleted cause of de	eath (Item 23a) (Type,	Print)	0 0 1		- TOAL IC			2111	7
			CHITRICITY			ath (Item 23a) (Type,	PEZ	Ke Kd	· WE	ZIMINE	IERP	()	2117	
	Sta Regist		31. Date filed (Month	CO	32. Registra	r's Signature	1	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 21, 2007 **Physician** 1:05pm Virginia Wellenkamp Latham /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2/2 F 82 126-16-3552 Yrs. New York Director Usual Residence of Decedent 10a Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Itame 23s or 28s-f eho 1 X Yes 2 □ No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 S. Parke Street Apt.B-27 21001 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0·12) 1.2. College (1-4or 5+) Editorial Secretary Civil SErvice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Edward Wellenkamp Edith Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ut. Pages 1 and partment of Health and opertant: If Item 27 is tury or other tr Howard J. Latham (Son) 109 W. Inca Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If eny Injury or once. Harford Memorial Gdns.2/26/07 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Hor Aberdeen, Maryland 2100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sicien and burial-transit attending pt for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Partill, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ cate has been sig , page 2 should b 3 Probably 4 mknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 4b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No 1 Yes rector, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending death. 1 Tyes 2 No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ά 4 - Homicide within 24 hours at To the Funeral D completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

10

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Name and address of p

31. Date filed (Month, Day, Year)

MAR

2007

Maryland 21215-0036

Itimore,

Box 68760

Records,

ivision of Vital

rson who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

		For State	State of Marylan		partment of I ertificate of			iene       /	U53Z1
		Registrar  1. Decedent's Name (First, Middle, La	st)		710410 07	Dodin	2. Date of Death	n	3. Time of Death
Physici	an	LOLETA	MOORE				Month 02	Day Year 10 2007	21:05 M
/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County of Deat	
Exami	e	SOUTHERN MARYLAN			CLINTON			PRINCE GEO	ORGE
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birti	nplace (State or Foreign untry)
Director		239-46-7759	□M 2X)F 74	Yrs.	Months Days	Hours Will.	10-19-19	932 NOR	TH CAROLINA
p ,		Usual Residence of Decedent  10a, State 10b, County	100 Cit	y. Town or I	ogetion.				10d. Inside City Limits
arylan ehow	5	MD PRINCE G		TLAND	Location				1 XYes 2 No
the Ma 28a-f	Director	10e. Street and Number	201.02		10f. Zip Code		10	Og. Citizen of What Co	unto/2
with t			E #220		20746			U.S.A.	unity:
eath w	Funeral	5000 LYDIANNA LAN	L # ZZU  12. Was Decedent Ever in U	.S. 13	. Was Decedent of I	Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	rican Indian,
ter dea	ä	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or iteme 23e or 28e-f ehowent, the Maulical Examinar must be motified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🟋 No	Specify:		Specify: BL	ACK
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Men	ုင	RUSSELL MOORE				LENORA S			
2 sh and is m		19a. Informant's Name/Relationship (ERWIN DEAN DIGGS/						City or Town, State, 2 ARLBORO, MI	
1 and 1 and 1 ealti 1 m 27		20a. Method of Disposition		1	position (Name of	DIGINOIT DI		20c. Location - City or	
S H S S S S S S S S S S S S S S S S S S		1 Burial 2 □ Cremation 3 [	Removal from State	emetery, cr	ematory or other pla	1		,	
rtant rtant		4 □Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice						CLINTON, MI FUNERAL HO	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other treumatic event, its Muulical any injury or other treumatic		21. Signature of Purietal Service Lice	-la a CC				LANDOVER,		)IIL
		23a. Part1. Enter the disease, dr con shock, or heart failure. List only	plications that caused the deat	h. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a ACUTE D						Onset and Death
/Medical		resulting in death)	a. Due to (or as a conseq		(1-101) 14	_ 117 [	pr (CC )   0   -		
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death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	☐Ectopic pregnand			Month	Day Year
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s that	by PI	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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aw require s been si	Completed	HYPERTENS	100				24a. Was ar		topsy findings available
The la	E						autopsy perform	ned? death?	completion of cause of 2 ☐ No
ysician: The is certificate his director, page	40	25. Was case referred to medical				26. Place of De	ath (Check only one		
ysici is ce direc	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2	ER/Outpati	ent 3 DOA	her: 4 Nursing I	Home 5 ☐ Reside	nce 6 ☐Other (Spec	cify)
ng Ph Ifter th	1	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo		28d. Describe ho	w injury occurred	
eath.	cat	2 Accident investigation 3 Suicide 6 Could not to				]Yes 2 □No			
or At after d Direct In by	Certification:	4 Homicide determined		ome, farm, s	street, factory, office		City or Town	reet and Number or Ru , State)	iral Route Number,
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying P	hysicien: To the best of my kno	wiedge, dea	ath occurred at the t	ime, date and place	e, and due to the ca	use(s) and manner as	stated.
the Ho lin 24 the Fu	Medical	one)	miner: On the basis of examina and manner stated.	ition and/or					``
To To	2	29b. Signature and title of certifier	ralegion MD.			se number		d. Date signed (Monti	
20		P /			D50	689	C	02/11/20	007
(10)		30. Name and address of person who SOUTHERN MARYL	completed cause of death (Iter	n 23a) (Type	e, Print) ANI	LKN	S RD CL	WEN WA	0735
Sta		31. Date filed (Month, Day, Year) FEB 16 2007	32. Registrar's Signa	ature					1
Regist	rair	LED TO TOOL	som to por	man.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🗎 🦪 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 Physician Month il OSEMARY MOORE 1117 2 ٥ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12403 Skylark Lane Bowie Prince George's 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Aug. 16, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 M 20 F 512-28-3498 75 Yrs. Texas Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r then "natural", or Iteme 23a or 28e-f ehow the Madical Examinar must be notified at 10d. Inside City Limits Director 1 XYes 2 No Prince George's Bowie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 12403 Skylark Lane 20715 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiene.
27 le marked other then "nr traumatic event, its Med Elementary/Secondary (0-12) College (1-4or 5+) Director of Finance City of Bowie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be William H. Williamson Myrtle C. Weber 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 12403 Skylark Lane Donald L. Moore / spouse Bowie, MD. 20715 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Depertment o Important: If eny Injury or once. 4 □Donation 5 □ Other (Specify) Metropolitan Crematory 02/17/2007 Alexandria, VA. 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lan /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c. as a consequence d). Examiner attending physicien and for use as the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 🗷 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺No 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Phymithin 24 hours efter death.

To the Funeral Director: After it completely filled in by the tuneral 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only 29b. Signature and title of continue Chief Medical Officer, 29d. Date signed (Month, Day, Year) 29c. License number Hospice of the Chesapeake 3/07 D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Michael J. LaPenta, MD, 445 Defense Highway, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2007 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Courtney Lawrence	1- For S Registra	tate	tate of Maryl	and / Dep <i>Ce</i>	artment o	of Heal	th and N	Mental I		Reg. No. 20	07 0632
Physician Medical Examine	er	dent's Name (First, Mid Courtney	Lawrenc		ning J	r.			2. Date of De		3 Time of Death 0345 hrs
	Pri	lity Name (if not institut nce Georges' Cou		umber)		4b. City, 1 Chev	Fown, or Loca erly	ation of Dea		4c. County of Prince Ge	
Funeral Director	214	Security Number  -29-2036 esidence of Decedent	6. Sex	7. Age (In yrs.		If Undo		Under 24H Hours Mi		F	Birthplace (State or Foreign Country) MD
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene with filem 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10a. Sta MD 10e. Str	Princet and Number  106 Gwinne	ett Lane  Aarried Armed F	cedent Ever in U		10f. Zip 2 Vas Decede	20727 Int of Hispani	c Origin? ( § xican, Puert	Specify Yes or No o Rican, etc.)	USA  14. Race - A White, 6	American Indian, Black,
5-0036 lied within 72 hours after de Hygiene de offer than "natural", or the Medical Examiner my Completed by Fu	15. De	Vidowed 4 Di cedent's Education (Spentary/Secondary (0-12) 1 th		de completed)		ent's Usual	king life. DO	Give kind of	work done tired)	16b. Kind of Busin	olack ness/Industry C School
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by F	Co: 19a. Info	er's Name (First, Middle urtney L. ormant's Name/Relation honne P.	Manning ship (Type, Print)	mother	. 19b. Mailii	ng Address	18.M L (Street and	aShor	nne P. Rural Route Nur	Maiden Surname) William mber, City or Town, Sie, MD 2	1.S State, Zip Code)
Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra	1 XB	thod of Disposition urial 2 Crematic conation 5 Other S attre of Funeral Service	pecify: /	om State	crematory or control Lin	osition (Name other place) COln Name and	Cem . Address of F	2 / 3	Date 17/07	20c. Location - Ci Brentwo	od, MD St. NE
Physician /Medical Examiner	Immedia or condi	t I. Enter the disease, o cre. List only one cause atte Cause (Final disease tition resulting in death) childly list conditions, adding to immediate Enter Underlying Cause or injury that initiated esulting in death). Last	a. Gunshot won b.  Due to (or as a b.)  Due to (or as a c.)		head  of):	K Hea	nry F	uner a	al Char or respiratory arr	pe1 Wash rest, shock, or heart	DC 20002  Approximate Interval Between Onset and Death
), be execu sician and unial - tra	IF FEMA 23b Was past	decedent pregnant in t 12 months?	he 1 Live b 4 Pregn known 9 Unkno	nant at time of de	2 Feath 5 C	etal death	ify)	ctopic pregn		23d. Date of del Month	Day Year
tal Records, P.C. cian: The law requires that certificate has been signed 1 ector, page 2 should be deta Be Completed by	25. Was	case referred to medica	Il Hospital			2	6.Place of De	eath (Check	1 Yes  24a. Was autop perfor 1 Yes  only one)	an 24b. Wer prior rmed? 2 No 1	Yes 2 No
Division of Vispital or Attending Physion or Attending Physions after death.  Ineral Director: After this filled in by the funeral director.  Certification: To		Suicide 6 Cou	28a. Date Feb 11, stigation ld not be	pax Year) 2007 e of Injury - At ho	28b. Time of 0007 hrs ome, farm, stre	Injury 2	8c. Injury at \	Work? 2 ✓ No	28d. Describe Subject sho	how injury occurred  t  Street and Number o	or Rural Route Number, City
D To the Hospital within 24 hours To the Funeral Completely filler		tifier 1 Certifying P	hysician: To the besominer: On the basis of and manner s	of examination a	ge, death occu				d due to the caus		stated
	29b. Sigi	e and address of person	Seef.	ND	23a)	. 29c.	O.C.M.E.	nber		29d Date signed February 11,	
State Registrar	31 Date	ha Greenberg MD filed (Month, Day Year) 16 2007		edical Exam		Penn St	treet, Balti	imore, MI	D 21201		

DHMH 17 Rev 1/2001 OCME 2006

07-01233

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Registrar	ate of Maryla		rtment o		Mental H		2 () Reg. No.	07 0632	
Physician/ Medical Examiner								2. Date of Death Month Day Year February 14, 2007		3. Time of Death 0835 hrs	
		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital  4b. City, Town, or Location of Death Clinton  4c. County of Death Prince Georg									
Funeral Director		579-30-7985	6. Sex	7. Age (In yrs. Ia	st birthday) Yrs	If Under 1 Year  Months Days	If Under 24Hrs Hours Min.		irth (MM/DD/YYYY)	D. Birthplace (State or oreign Country) Indiana	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. Street and Number 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number 10d. Inside City Limits 1 Yes 2 X No. 10c. Street and Number									
	eted by Funeral	Specify: WILLE						White			
	To Be Completed	John McDonald Flor					Flora	a Pugh			
		19a Informant's Name/Relationship (Type, Print)  Martha L. Crabtree -Sister-in-law  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3515 56th Street, Cheverly, MD 20784									
		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signefure of Funeral Service Licensee  22. Name and Address of Facility  23. Superfuse of Funeral Service Licensee  24. Donation 5 Other Specify:  25. Name and Address of Facility  26. Place of Disposition (Name of cemetery, crematory or other place)  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Location - City or Town, State  Alexandria, Virginia									
Physician /Medical Examiner	ician dical  23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately 1. A. Inyactes 1									Approximate Interval 8etween Onset and Death	
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Obsease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
be execut ician and urial - tra	Medical	UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Prostate Cancer  1 Yes 2 No 3 Probably 4 V Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?									
Vital Revysician: The his certificate director, page	Be Co	25. Was case referred to medical examiner?					Death (Check o	1 Yes :	2 No 1	Yes 2 No	
on of Virginal on of or or or or or or or or or or or or or	유	1 Ves 2 No loss learning Home 5 Residence 6 Other:  27. Manner of Death 1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 1 Ves 2 No 28d. Describe how injury occurred									
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Di To the Hospital within 24 hours a within 24 hours a completely filled	Medical	(Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
(15)	ğ	29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month)  February 15, 2007									
lut ye		30. Mame and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
Sta	ate	31. Date filed (Month, Day Year)	32. Regi	strar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Febru Verna Bee Musselman /Medical 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore lestown Mar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Hours 218 10 4417 Yrs 98 Director 1908 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland neat of Health and Mental Hygiene.
ant: if item 27 is marked other than "neturel; or iteme 23a or 28a-f show ury or other traumatic event, ir a Medical Exprinar marked recipied at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes ZX No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane RGN 208A 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 SWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Newkirk Sue Syfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4638 Dower Drive Ellicott City, MD 21043 Carol Carew/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) Meadowridge Cemetery! 2-16-2007 Elkridge MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) Spelo /Medical Due to (or as a consequence of): **Examiner** emen Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury years Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 1 Tes 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 2 ER/Outpatient 3 DOA his Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and ritle of centre 29c. License number 29d. Date signed (Month, Day, Year)

(3) or 3

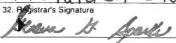
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) FEB 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111



			1 - For State Registrar	State of M	aryland		artmen rtificate			ınd M		giene Reg. No.	20	07	060	326
	Dhysisi	22	1. Decedent's Name (First, Middle, Last	)							2. Date of Dea	ith Day		Year	3. Time of	Death
	Physici /Medi		Mabel Irene Mille							-	Februa			2007	8:00	P M
1	Examir	er	4a. Facility Name (If not institution, give						Location of	f Death		4c. (	County	of Death		
-			Goodwill Mennonit  5. Social Security Number 6. Se		o /loure la	ast birthday)	Grar If Under	tsvi	ille If Under 2	DA Hes	0. Data of Dist		arr			
	Funeral Director			M 280F	96	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day Aug • 20	, Year)	.0	9 Birtho Cour Mary		or Foreign
	yland		10a, State 10b. County	· ·	10c. City,	Town or Lo	cation							1	0d. Inside Ci	ity Limits
	8-f el	tor	MD Garrett		Acci	dent									1 🔀 Yes	2 🗆 No
	라 다 6. 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of V	What Cour	itry?	
	eth w	rail	101 Town View Dr.,	Apt. 18			2:	1520				USA				
Maryland 21215-0036	72 hours after deeth with the Maryland natural', or items 23a or 28s-f ehow disal Examinar must be rodified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		1	Vas Deced fYes, spec I□Yes 2			in? (Spe , Puerto l	city Yes or No- Rican, etc.)			e - Americ ck, White, Whi	etc.	
2-0	"natural",	ted	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	lent's Usua	l Occupa	ition	of work in		16b. Kin	d of Bu	usiness/Ind	dustry	
7	d within piene. rr than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT us	e retired)	uring most	OF WORKIN	ig					
2			12			Homema	aker					-		ome		
and	B E D	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden S	Suman	1ө)		
ž	hould d Mer marke	은	Richard Younkin  19a. Informant's Name/Relationship (Ty	ma (Paint)		405 44-75		(0)			Yommer	-				
Ma	s 1 and 2 should if Heelth and Mer item 27 is marke other treumatic	12	Ralph F. Miller/Son								/ Route Number					
<u>a</u>	Heel Heel tem		20a. Method of Disposition	1	20b. Pla	ace of Disno	sition /Nam	a of			Accide			2152 City or To		
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			metery, cren		ther place	1	. 17				•		
	교육원급 .		21. Signature of Funeral Service Licens		210	Ceme		d Addres	reD s of Facility	No.	,2007 wman Fu	ACCI	laer	nt, M	) )	
ñ	Depa Impo any i		De Lycu	lumi	2 m						sville,			536	F.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or heart taillere. List only or immediate Cause (Final disease or condition resulting in death)	Due to (or as	10. Q M [ "	Fron	er the mode	of dying	, such as c	cardiac oi	r respiratory arr	est,			Approximate Interval Betwoonset and E	veen Death
8760,	icate be executed physicien and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	evel	rul	V130	=10	v (	dis	e0 e		-	j	yea	115
P.O. Box 68	I the death certif by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal c	death 3	Ectopic pre Other (spe					23	3d. Dat Mor	e of delive	•	'ear
rds, P	w requires that been signed to should be det	Ď	Part II. Other significant conditions cor	ntributing to death b	ut not result	ting in the un	dertying ca	use give	n in Part I.		23e. Did tot		,		e cause of de	
Division of Vital Records,	Physician: The law re this certificete has be al director, page 2 sho	Completed	·							_	24a. Was a autops perform	У	þ	Vere autoportor to com leath?	sy findings a pletion of ca	vailable use of
Vit.	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:					_		Check only on	-				
on of	Attending Phys or death. ector: After this by the funeral dir	tion: To	1  Yes 2 No   27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Da)		R/Outpatient 28b. Time of Injury		C. Injury Work	4 LOUNUIS	2	e 5 Reside 8d. Describe ho				)	
Divisi	i di di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At hom :. (Specify)	ne, farm, stre	et, factory,				8f. Location (St. City or Town	reet and n, State)	Numbe	er or Rural	Route Numb	9 <b>9</b> 7,
	To the Hospital within 24 hours of To the Funeral completely filled	edicai	29a Certifier 11 <sup>th</sup> Certifying Physical (Check only one) 2 ☐ Medical Examin	ior: On the basis of	examination	on and/or inv	estigation,	in my opi	nion, death	occurre	d at the time, da	ate and o	slace a	ind due to	the cause/el	
	To the vithin 2 To the comple	Ž	29b. Signature and title of certifier		11.1	<u></u>	29c.	License	number		25	9d. Date	signed	(Month, E	lay, Year)	
			Milling /	men	MI		D	00	257.	59	F	ebr	Uqi	Hy 15	.200	7
			30. Name and address of person who co	mpleted cause of de	nn, A	23a) (Type, F 1 D	Print) PO	Bo	x 2 4	17.	* CCIO	1px 7	+M	10 2	-152	0
Ī	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 20	32. Registra	r's Signatu	re	and s									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 12, 2007 **Physician** 7:43 a.M Delores Moore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 579 54 9204 1 □ M 2 F 73 Director 08-16-1933 Washington, DC Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits \$€ Yes 2 □ No Director MD Prince Georges Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 3004 West Avenue 20747 United States death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2, ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3. Widowed 4 Divorced 16b. Kind of Business/Industry
Bureau of Engraving the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Examiner US Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fil ont of Health and Mental H t: If item 27 is marked oth y or other traumatic even Be Rosetta Ames James Bowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3004 West Avenue, Forestville, MD 20747 Charles Robinson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 ☐Removal from State Department or Important: If any injury or once. 17 2007 KIVERDALE MARGIAND 5 ☐ Other (Specify) Donation WERDALE CREMATORY Signature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3015 12th Street, NE Washington, DC 2 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTHGROSCIEROTIC CARDIOVAS CULAR DISEASE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical death certificate attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION DABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed SEIZURE DISORDER PAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 2 ₽ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hosping.
within 24 hours after
To the Funeral Dir 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTEMOING PHYSICIAN 1)52900 02-12-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 CENTRAL AV H301, LANDOVER MD 20785 MOMOHMO

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 15 2007

State of Maryland / Department of Health and Mental Hygiene 06328 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARY 2 '00 PM MILLS 2007 eb 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital P.G. Laurel 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 XF 79 Yrs. Director 217-24-9523 2/1/28 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examinar injust be notified at Prince Georges 1 Types 2 □ No MD Directo Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Laurel Park Drive 20707 USA by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 🎾 o Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Micro-graphics Fed. Gov't 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, SDES. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecil Brown Catherine Berceff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Alder/Daughter 14800 4th St. Apt 101B Laurel, MD 20707 20a. Method of Disposition
14 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 2/16/07 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood,MD 20722 23a. Part1. Enter the disease for implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ch roniz obstutive Compriseese **Physician** reans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 □ No 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes Division of Vital 1 Yes 2 TND or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending death. investigation 1 TYes 2 TNo completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28998 PRITAM 55AINI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chen Long (0) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month McMAHAN FRANCES AUDREY ADAMS 6:00 A M 2007 Feb. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Federalsburg 117 W. Central Avenue | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Information of Months | Days | Hours | Min. | June | 28,1926 | Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**基**F 80 Yrs. 222-12-9576 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural" any injury or other treumatic auge. 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Federalsburg MDCaroline Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21632 117 West Central Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐XNo Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11-Grad. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Narcissa Neighbors Frank Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24437 Asbury Dr., Denton, MD 21629 Keith McMahan/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18,2007 Federalsburg, Hill Crest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom, Funeral Home, Federals burg, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HUDOXIOL Due Id (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Jycas Multisystem Sequentially list conditions, in any, leading to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): nding physicien end use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed i page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 2 Accident Director: 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerei 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/14/07 40059973

Registrar

DHMH 17 Rev 1/2001

State

100 Bramble St. Cambridge MD 21413

ess of person who completed cause of death (Item 23a) (Type, Print)

10 hn50n

Year)

31. Date filed (Month, Dey

07-00995 **Faith Morris** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 5, 2007 Medical Examiner 0000 hrs -AITH D. MORRIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6625 Whitesburg Road Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours Director 215-38-1013 Country) MD 10 1 M 2 X F 06 1091 Yrs 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No 28a-f show MD "natural", or items 23a or 28a-f shov Examiner must be notified at once. TALKOT TRAPPE hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21673 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married Yes BLACK 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Perent of Health and Mental Hygiene int: If item 27 is marked other than "" NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) NELLIE WALLACE æ GEORGE H. PETTY 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic George Herry Brother 29143 KAISMOR UT TRAPPE, MD 21673 20a Method of Disposition 20b. Place of Disposition (Name of cemetery. Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-17-07 NANTICOKE, MID NANTICOKE (EMETERY 4 Donation 5 Other Specify. 22. Name and Address of Facility
MESSICK FUNERAL LAME
BLYALUE, MD 21814 21. Signature of Funeral Service Licensee My Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause on each line /Medical Death a. Positional Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 V No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Records, P.O. φ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 No ✓ Yes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death Subject fell into position which compromised FOUND: 1 Natural 1 Yes 2 V No Pending Feb 5, 2007 1545 hrs 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 6625 Whitesburg Road, Snow Hill, MD determined (Specify) residence 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier February 6, 2007 OCME 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ROSA FRANCES MOSES tebruary 19 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** 14 10 If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2XF Months 91 OCT.5, 226-18-6552 1915 VIRGINIA Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes XXNo Director MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be n 3635 MOSES WAY 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No SpecifWHITE Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER KINNEY LEONARD ELLA LEE WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 27 OUANAH F. PARKER-SON 3635 MOSES WAY, WALDORF, MD 20602 permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other once, or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State PETER'S CH. CEM. 2-24-07 WALDORF, MARYLAND ST4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call the each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No <sup>2</sup> 1 📜 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MURPHY ERIKA FEBRUARY 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUPKINS THE JOHNS HUSPITAL BALTIMERE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 9/28/1939 Months Days Hours 1 □ M 2X F 178-46-2684 Director 67 Germany Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits MD Harford Aberdeen 1 XI Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 635 Aberdeen Thruway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes & No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heinrich Hetzel Margarete Wimmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Girtha Murphy (Spouse) 635 Aberdeen Thruway Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Mem. Gdns. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 2/27/07 Aberdeen, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Abardeen. Maryland 21001-3399 21. Signature of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LEFT minute /Medical Due to (or as a consequence of) **Examiner** MULTI OREAN SYSTEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine SEPSIS as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria LIVER Physician/Medical CIRRHOSIS IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2 No detached 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 № No ၉ 1 💹 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar

VADIVELL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUDHAKAR

MAR

2.0 32 Registrar's Signature

RES - 000

NORTH WOLFE STREET

FEBRUARY 21

BALTAMORE

2607

MARYLAND21787

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	Physicia	20	1. Decedent's Name (First, Middle	e, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		WILLIAM NET								EBRUARY	T	2007	7:55AM <sup>™</sup>
A.	Examin	er	4a. Facility Name (If not institution				4b. City, T			f Death			nty of Death  TALBOT	
	Funeral		9787 TILGHMAN  5. Social Security Number		AD. '. Age (In yrs. la	st birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
Ы	Director		213-22-4767	<b>™</b> 2□F	77	Yrs.	Months	Days	Hours	Min.	(Month, Day,	1 <b>929</b>	MAR	YLAND
	DU A		Usual Residence of Decedent  10a, State 10b, County		10c. City.	Town or Lo	cation						11	Od. Inside City Limits
	f sho	ō	MD	TALBOT			ANIEL							1 □Yes 2 <b>X</b> No
	r 28a-	Director	10e. Street and Number				10f. Zip (	Code			10	g. Citizen	of What Coun	try?
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	r dea	Funeral	11, Marital Status	Armed For	dent Ever in U.S ces?	i. 13. \	Vas Decede Yes, speci	ent of His fy Cuban	panic Orig	gin? (Sper , Puerto F	cify Yes or No- lican, etc.)		ace - Americ Black, White,	
36	s affe	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, Give Year or Da	)		□ Yes 2	No	Specify:			Spe	city: WHI	rr
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215	nin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	college (1-	4or 5+)	(Give lite. L	kind of work DO NOT use	k done du e retired)	uring most	of workin	g			
2121	Hygiene Hygiene other tha	Completed	10	0		BR	ICK M						TRUCTIO	ON
and E	De till High off	Be	17. Father's Name (First, Middle,								(First, Middle, M		name)	
Maryland	should nd Men s marks umatic	ဥ	GEORGE C. NEW			19b Mailin	n Address	(Street a			Route Number,		wn. State. Zio	Code)
æ ∑	olith an 27 Is: r trau		BOBBIE NEWNAM/								ELS, MD			
ē,	of Hee		20a. Method of Disposition		CO.	ace of Dispo metery, cren	sition (Nam	e of her place	)	Di	ate 2	Oc. Locatio	n - City or To	wn, State
altimore,	Pages nent of ant: If it ury or o		1 Burial 2 Tremation 4 Donation 5 Other (S		tate	-			'	r. 2	/17/200	7 STE	VENSVI	LLE, MD
Balt	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Heelith and Mental Hygiene. Department of Heelith and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Mcdical Examinar must be notified at once.		21. Signature of Funeral Service		e CF	F	Name and ELLOW:	S, H	ELFEÑ	BEIN	& NEWNA	AM FU	NERAL 1	HOME PA
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death.								1001	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition		28 BROV	ASCUL	AR	AZ	CIDE	v,-				Onset and Death
	/Medical Examiner		resulting in death)	- u.	or as a consequ									
		-	Sequentially list conditions, if any, leading to immediate	b. Our to fe	Fas a conseque	unee off								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>(</b>										
oʻ	exect an and rial-tra	Еха	resulting in death) Last	Due to (d	or as a consequ	ence of):								
3760,	The law requires that the death certificate be executed the hes been signed by the ettending physicien and bege 2 should be detached for use as the buriat-transit.	ical		d										
	thet the death certificated by the ettending phase detached for use as to	Physician/Med	IF FEMALE:	00- 11										
Вох	ettend for us	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregnan rth 2 □ Fetal ant at time of de	death 3	Ectopic pre						Date of delive Month	ry Day Year
P.O.	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno		atti SE	JOINEI (Spe	CII <b>y</b> /						
۳.	s thet ned by e deta	by Ph	Part II. Dther significant condition	ons contributing to de	ath but not resu	Iting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use c	ontribute to th	e cause of death?
ğ	w requires to been signed should be to shoul									_	1 ☐ Ye	s 2 🗆 No	3 Prob	ably 4 🖄 Unknown
ည္ထ	e law re hes bea je 2 sho	Completed									24a. Was an	24	b. Were autop	psy findings available inpletion of cause of
œ ,		Con									perform	ed?	death?	2 No
i da	ictan: Th certificete rector, peg	Be	25. Was case referred to medica examiner?	Hospital:					~		(Check only one			
o d	Physical dir	5	1 Yes 250 No 27. Manner of Death	28a. Date o		R/Outpatien 28b. Time of			4 🗀 1401		ne 5X Resider 8d. Describe how			/)
5	Attending Physician: r death. sector: After this certifice by the funeral director.	tion	1 ⊠Natural 5 ☐ Pendir 2 ☐ Accident investi	ig (Month	n, Day Year)	Injury	м	Bc. Injury Work 1   Y	? 'es 2 □ !			w anjury oo	Junea	
É		ertification:	3 Suicide 6 Could 4 Homicide determ	ined 280. Place	of Injury - At hor g, etc. (Specify)	me, farm, str	eet, factory,	office		2	8f. Location (Str City or Town,		mber or Rura	l Route Number,
_	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	O		ng Physician: To the										
	To the Hospite within 24 hours To the Funeral completely filled	edicai	(Check only 2 Medical one)	Exeminer: On the ba and mann	sis of examinati er stated.	on and/or in	estigation,	in my op	inion, deat	th occurre	ed at the time, da	te and plac	e, and due to	the cause(s)
	Your Tour Comp	ž	29b. Signature and title of certifie	10				License			29		ned (Month, I	
	, ,\		P fihret	They have				1200	519	800		2/	1,2/0	7
	4)		30. Name and address of person	·		23a) (Type,		cs	ind					
	Sta		31. Date filed (Month, Day, Year,	32 Re	egistrar's Signat		A.*							
	Registr	वा	FEB 1.3	2001	A STATE OF THE STA	100	1. 2						<u> </u>	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** DONALD R. NICHOLS 9:30 Å 2007 11 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING & REHABILITATION CT. Year If Under 24 Hrs. Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 80 Director 137-20-1811 OCT. 26, 1926 NEW JERSEY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 X Yes 2 □ No Director MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 139 OYSTER LANE 21842 USA Funeral iral", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Mamied Nichols, donald R. Baltimore, Maryland 21215-0036 1∐Yes 2XINo Specify: <u></u> 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) MANAGER 12 AUTO BODY SHOP 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NICHOLS ပ RAYMOND MAY McCLAIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any Injury or other to once. ARABELLA M. NICHOLS/WIFE 139 OYSTER LANE, OCEAN CITY. MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 □ Duna. 4 □ Donation 5 Other (Specify) CREMATORY OF DELMARVA 2/12/07 DELMAR, DELAWARE 21. Signal re y F neral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Rheimer eco Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Unknown 1 ☐ Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes alZ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: DA No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 286. Sign Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar
DHMH 17 Rev 1/2001

State

D 1209

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sean Bolaji Oderinde 2007 06335 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 14, 2007 Medical Examiner 1520 hrs BOLAJI SEAN ODERINDE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hospital Cheverly Prince George's 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign LAGOS **Funeral** Min Director Months Davs Hours NONE 06-07-1988 1 X M 2 Country) NIGERIA 18 Usual Residence of Decedent any 10a State 10c. City. Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No PRINCE GEORGE LANDOVER must be notified at once, ages I and 2 should be filed within 72 hours after death with the Maryland or of Health and Mental Hygiene. It. If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 4083 WARNER AVENUE #D1 20785 LAGOS, NIGERIA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 2X No Yes Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify BLACK þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 STUDENT 12th PRIVATE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be BOLAJI ODERINDE MODUPE SANUSI ဥ 19a Informant's Name/Relationship (Type Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD MODUPE OBERINDE/MOTHER 4083 WARNER AVE #D1 LANDOVER, MD 20785 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 A Cremation 3 Removal from State crematory or other place) RIVERDALE CREMATORY 02-17-2007 RIVERDALE, MD Donation 5 Other Specify. 21. Signature of Fuheral Service 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and (Wedical Death a. Gunshot Wound to Head Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) g physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Records, P. Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? page 2 2 No Yes 2 ✓ Yes 25. Was case referred to medical 26.Place of Death (Check only one Division of Vital Be Hospital: 1 Other<sub>4</sub> Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury (Month, Day Year) Feb 13, 2007 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Certification Subject shot 2033 hrs Natural 5 Pending 1 Yes 2 ✓ No 24 hours after death. Funeral Director: in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 4007 Coopers Lane, Hyattsville, MD (Specify) Outside of apartment bldg 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

Registrar

B 16 2007 32. Registrar's Signature

Assistant Medical Examiner

masiel

30. Name and address of person who completed cause of death (Item 23a)

a ling

Melissa Brassell, MD

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 15, 2007

			1 - For Stata Registrar	State of M	/laryland	d / Depa	ırtment	of He	ealth a		tal Hygi	ene	07	06336
	Physici		1. Decedent's Name (First, Middle, La Peggy Lee O'Donn									Day _	A ear	3. Time of Death
0	/Medic Examir		4a. Facility Name (If not institution, given 408 Parkwood Dri	ve street and number	r)	4b. City, Town, or Location of Death Salisbury  5. last birthday)  1f Under 1 Year  1f Under 24 Hrs.  1s. Date of Birth (Month), Day, 1st, Town or Location  Salisbury  1of. Zip Code 21804  U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  1	4c. Count	y of Death						
	Funeral Director		214-26-9870	Sex 7. A 1 □ M 2 🛣 F	Age (In yrs. Ia					Min.	Date of Birth Month, Day,	(ear) 1929	Cou	place (State or Foreign ntry) yland
1	Marylend -f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic	0	10c. City									10d. Inside City Limits 1 X Yes 2 □ No
3	or 28a-	Funeral Director	10e. Street and Number			Dalis	10f. Zip Co				10	g. Citizen of		ntry?
° Q	s 23s	rai	408 Parkwood Dri		. =								SA	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryler Depertment of Health and Mental Hygiene. Importants: if item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examinar must be notified at ODGs.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2 2 If Yes, Give Year or Dates	s? <b>₫</b> No					jin? (Specity , Puerto Ricar	Yes or No- n, etc.)		ce - Ameri ack, White, fy: Wi	
215-0	hin 72 ho 9. 9n "natur Medical I	Completed	15. Decedent's E (Specify only highest gi	ade completed)	r 5+)	(Give I life. [	kind of work of OO NOT use	done du retired)	tion uring most	of working		5b. Kind of E		
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Maryland 21215-003	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Las (First Name Unkn	own) Haas	S								me)	
	nd 2 shillth and 27 is m		19a. Informant's Name/Relationship Ellen Wattay/Fri				-							Code)
ore,	of Hear Item		20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name	of	1			c. Location		own, State
Baltimore,	ment tant: if		1 ☐ Burial 2 X Cremation 3 [ 4 ☐ Donation 3 ☐ Other (Special	<sup>(h)</sup>	A	atory o	f Delma	irva	2			elmar		aware
Ba	Depermit Deper Impor eny in		21. Signature of Funeral Service Lige	Sell	w	Ze   12	Name and A	Address Fune	of Facility ral l cean (	Home,	P. 0. oad, S	Box 3: alisb	171 1ry,	MD 21802
		7		nplications that cause one cause on each	ed the death. line.				such as c	cardiac or res	piratory arres			Approximate Interval Between Onset and Death
0	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Meta Due to (or a	stati is a consequ	lence of):	6610	1		an Cl				
	be sit	lner	Sequentially list conditions, I any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	is a nonsequ	ianda uf):							11	
,160,	be executed sicien and burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due to (or a	ıs a consequ	ence of):								
89	ificate g phys as the			_ d								- 1		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attanding physicien and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3 🗌			_				ate of deliv	ery Day Year
	uires that n signed b lid be deta	þ	Part II. Other significant conditions	contributing to death	but not resu	Iting in the un	derlying caus	se giver	n in Part I.		23e. Did toba	-1		he cause of death?
CO	aw requir s been si 2 should	olete										24b.	Were auto	psy findings available
8	: The law cete has	Completed									performe	d?	prior to co death? 1 Yes	mpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Ha anitali						of Death (Ch	eck only one)			
of	Phys this ral dii	5 T	1 ☐ Yes 2 ☐ No 27, Manner of Death	Hospital: 1 Inpat				J	4 🗀 IVUI:		5 Residen			(y)
ion	Attending r death. ector: After by the fune	ation	Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury		Work?	,		ouscilgo non	inquiry occu		
Division of Vital Records,	i di di	Certification;	3 Suicide 6 Could not to determined	289. Place of I	njury - At hor etc. (Specify)	me, farm, stre	et, factory, o	ffice		28f. L	ocation (Stre City or Town,	et and Num State)	ber or Rura	al Route Number,
	ne Hospital n 24 hours a ne Funerei I	Medical	29a. Certifier Check only one) Certifying P	hysician: To the bes miner: On the basis and manner:	st of my know of examinati stated.	wledge, death ion and/or inv	occurred at estigation, in	the time my opi	, date and nion, death	place, and d	lue to the cau the time, dat	se(s) and m e and place,	anner as s and due to	tated. o the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	1.A	) n	20	,			278	290	Date signe	9-0	Day, Year)
_			30. Name and address of person who	completed cause o	eath (Item	23a) (Type, F	1	, 17	77		lich	111	2	1802
	Sta Registr		31. Date filed (Month, Day, Year)	-	itrar's Signati	ure	Anne R	~ 1/	J J_	00/	1000	)	) /	1002

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Alvina Μ. Poe 12 February 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Plata Le haif 1 Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) March 8, 1936 9. Birthplace (State or Foreign Country), Glennville, Ga. Social Security Number **Funeral** Days Months 1□M 2🛛 F 70 261-58-2748 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 United States 2404 Plenty Gates Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ģ 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer Private 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Mae Mobley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winnie D. Singleton /Daughter 2404 Plenty Gates Lane Waldorf, Md. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☑ Removal from State Feb.17,2007 Robert Chapel Tyson, Ga. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Alexander 5538 Mariboro Pike/Forestville, Md. 20747 M 01 085 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sep515

Due to for as a consequence of): Se /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Joscaes or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 / No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only The) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ Ño ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

FEB 15 2007

DR. J. HARRING

31. Date filed (Month, Day, Year)



turing 30. Name and address of person wito completed rause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 9, 2007 09:47 AM Swain Parks, Jr. Samuel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cambridge Dorchester Dorchester General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 13, Year 934 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 72 217-30-7647 Maryland Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental hygiene.

Int: If Item 27 is marked other then "natural", or Items 23s or 28s-f show ary or other traumatic event, the Medical Examinations at a notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Wingate MD Dorchester Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21675 LISA 2125 Farm Creek Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2X No Yes Give 1X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown fabricator wire cloth mfg. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Elizabeth Robinson Samuel Swain Parks, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Light St. Cambridge, MD 21613 Janice Wilson permit. Peges 1 end Department of Heelth Important: If item 27 eny injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Parks Family Cem. Feb.13,2007 Wingate MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. Bo = k. 700 Locust St. Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician rena 3 week /Medical Due to (or as a consequence of). Examiner Volume Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit or Attending Physicism: The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ፩ 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes Atter this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturat To the needs after death, within 24 hours after death.

To the Funeral Director: After the funeral in by the funeral in by the funeral funeral in the funeral 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ih 8 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

			1 - For State Registrar	State of M	larylan		artment rtificate			nd M		giene	07	06340
П	Physici	an	Decedent's Name (First, Middle, Las	•		Dawh	-m				2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi		Doris Br	radley	·)	Parha	4b. City, T	·		( Death	Februa			2:12 AM
	Examir	ıer	4406 Richard Way		,			urlo	_	Death		Dor	chest	er
DO OF VITAI RECORDS, P.O. BOX 68760, Baltimore, Maryland 21215-0036  Jaing Physician: The law requires that the death certificate be executed Baltimore of Health and Mariel Business.	Funeral Director		210 20 3370	9x	ge <i>(In yr</i> s. 79	last birthday) Yrs.	II Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Date March	<sup>h</sup> Year) 2, 1927		place (State or Foreign
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
$\overline{}$	Maryl	to	MD Dorches	ter		Hurloc								1 ☐ Yes 2 No
3	h with the	Funeral Director	10e. Street and Number 6435 Cabin Cre	ek Road	1		10f. Zip (	Code 643				10g. Citizen of USA	What Cou	intry?
2980	ours after deet rai', or iteme 2 Examiner mu	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 P If Yes, Give Year or Dates	? No		Was Decede If Yes, specif	v.	panic Orig , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		2007  County of Death Dorchester  927  Second of Death Dorchester  927  9. Birthplace  927  10d.  14. Race - American Black, White, etc.  Specify: White and of Business/Indust  White, etc.  Specify: White and of Business/Indust  White, etc.  Specify: White and of Business/Indust  White, etc.  Specify: White and of Business/Indust  White Sumame) nders  Town, State, Zip Co. D 21643  Cation - City or Town, t New Mark  1 Home, P. 1613  Application - City or Town, or  J  State, Zip Co. D 21643  Cation - City or Town, t New Mark  1 Home, P. 1613  Application - City or Town, or  J  State, Zip Co. D 21643  Cation - City or Town, or  J  State,	, etc.
1215-0	within 72 h iene. • than "natu ihe Madical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		5+)	16a. Deced (Give life.	dent's Usual kind of work DO NOT use home	Occupati done du retired)	ring most	of workir	ng			ndustry
/land ?	uld be filed Mental Hyg Irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Thomas Harry Hum	mer				1				Maiden Sumai Saunde		
	end 2 sho sath and I n 27 te me er treume		19a. Informant's Name/Relationship (7 William Alex Parh			6435	Cabin	Cre	ek Ro					p Code)
imore	Pages 1 nent of He ant: if iten ury or oth		20a. Nethod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		,	Place of Dispo emetery, crer St New					ate 2,2007			
Balt	Depertition of the point of the		21. Signature of Funeral Service Licen.	see >		22	. Name and	Address	ol Facility			neral H MD 2161		P.A.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Hospital or Attending Physician: The law requires that the death certificate be executed to the Hospital or Attending Physician: The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the Maryland or The law requires that the death with the death with the Maryland or The law requires that the death with the death w	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that cause one cause on each a. AUV M	d the death line.	1	er the mode	,		,	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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Box 6	thet the death certificate be e ed by the ettending physicien detached for use es the burit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ Ho 9 □ Unknown	d	e ol pregna	incy	Ectopic pre							ery Day Year
о_	w requires that been signed by should be deta	Ď	Part II. Other significant conditions co	ontributing to death	but not resu	ulting in the u	nderlying cau	use given	in Part I.		23e. Did to			
	ysician: The law re is certificete hes bec director, page 2 sho	Completed									24a. Was a autop perfor 1 🗆 Yes	sy med?	prior to co death?	impletion of cause of
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ion of	ding Ph After th funeral	ation; To	1 ☐ Yes 2 <del>10 No</del> 27. Manner of Death  1	28a. Date of Inj (Month, D.		ER/Outpatien 28b. Time of Injury		c. Injury a Work?		2	ne 5 □ Resid 8d. Describe h	ence 6 Colt ow injury occur		home home
Divis	tal or Attences setter deathel Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	ijury - At ho tc. (Specify	ome, larm, str	eet, lactory,	office		2	8I. Location (S City or Tow	treet and Numb n, State)	er or Run	al Route Number,
	To the Hospital or Attentwithin 24 hours effor deatl To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exam	/sician: To the besiner: On the basis and manner s	or examinal	wledge, death tion and/or inv	occurred at restigation, in	t the time, n my opin	, date and nion, death	place, a	nd due to the o	ause(s) and ma date and place,	anner as s and due t	stated. o the cause(s)
)	With To I	2	29b. Signature and title of certifier	luw				License r		8				
			30. Namy and odress of person who de Michael Porde	Pew M	death (Item	1 23a) (Туре. ОЭ С°С	Print)	1/2	volo	ck.	mel	216	2.1 County of Death Orchester  9. Birthplace (State Mary Land)  10d. Inside Country?  4. Race - American Indian, Black, White, etc.  Specify: White dof Business/Industry  7. home  Sumame)  10d. Inside Country?  4. Race - American Indian, Black, White, etc.  Specify: White  dof Business/Industry  7. home  Sumame)  10ders  Town, State, Zip Code)  21643  ation - City or Town, State  New Market  Home, P.A.  613  Approximal Interval Be Onset and Interval Be Onset	>
	Sta Registr		31. Date filed (Month, Day, Year)	2007	rar's Signa	ture	6	6					00.88	

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Please Type or Print in Black Indelible Ink.—Ensure All Copies Are Legible. amend 11em 24a per verb g865 3-1-07 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year WILLIAM **POWERS** 02 20 2007 1800 BRENT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F 44 Yrs 215-74-3274 10-25-1962 WASHINGTON, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ALLEGANY FROSTBURG MD1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10706 NEW HOPE ROAD 21532 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY McLANE POWERS ROBERT L. POWERS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $10706\,$  NEW HOPE ROAD FROSTBURG, MD  $21532\,$ 19a. Informant's Name/Relationship (Type. Print) PATRICIA POWERS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MICHAEL CEMETERY 2-24-2007 FROSTBURG, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. Man M00547 FROSTBURG, MD 21532 Sower Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio ente Due to (or as a constituence of): disease or condition resulting in death) alcoholic cardion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events alcoholism resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Examiner** or Attending Physician: The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760, certificate this After death.

signed by the at d be detached for funeral within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

23a or 28a-f

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examine once.

**Physician** 

/Medical

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one) 29b. Signature

31. Date filed (Month, Day, Year)

and title of certifie

Baltimore, Maryland 21215-0036

the Medical Examiner must be notifled at

Director

Funeral

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Completed

Be

State Registrar

5 Steven

2007

10018216

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seton 900

Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H		•	giene- U Reg. No.	5 1	00046
	1		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Mark Steven	Po	ontorno				RY 16,2		12:53AM
7	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of De	ath	4c. County of	t Death	
			CAROLINE HOSPIC	E HOUSE		DENTON			CAROI	LINE	
	Funeral		5. Social Security Number 6. Sex	-0-	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Birt in. (Month, Da	h v. Year)	9. Birthplac	e (State or Foreign
	Director		214-12-4116	M 2□F	50 Yrs.			AUG • 11	,1956 W	VASH.	,D.C.
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ncation				10d	. Inside City Limits
	aryla sho	5	MARYLAND CAROLI	NE		STON				100	1 □ Yes 2/□X%o
	Ne N 28a-1	ect			I ILL.				10a Citima at 14/1		
	With t	급	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		17
	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show then "netural", or items 25e or 28e-f show the Madical Examil ar must be indiffed at	Funeral Director	103 BACK LANDING	RD.  2. Was Decedent 6	Ever in U.S. 12	2165		/Consider Voc or No	U.S.A.	- American	Indian
	its m	Ę,	11. Marital Status  1 ☐ Never Married 2 ☒ Married	Armed Forces?		If Yes, specify Cuba	in, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Bleck	, White, etc	
36	rs aft		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ (1) If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify₩	VHITE	3
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D	illed Hygi other	Bec	17. Father's Name (First, Middle, Last)		- 02.13	JICILE OOF		lame (First, Middle,			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Pyglene. Itsm 27 is marked other than "natural", or itsms 23a or 28a-1 show other traumatic avant. Its Medical Examinar Insulation in Millian at	To B	PETER JOSEPH PO	NTORNO			JOANN	E CATHER	INE GII	LOTI	
37	shou ond N on man	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailii	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town, S	tate, Zip Co	ode)
Σ	ond 2 belth a 27 to		DEBORAH R. PONT	ORNO-WI	FE 103	BACK LA	ANDING	RD., PRE	STON, ME	216	55
ē,	ts 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location - C	ity or Town	, State
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altimore,	permit. Pages 1 and 2 Department of Heelth a Important: if itsm 27 is any injury or other tra once.		21. Signature of Funeral Service License			2. Name and Addres	ss of Facility				
ä	Depa Impo any to		Mull	K		RAYMONE	FUNE	RAL SERV	ICE, P.	, A .	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not ent	er the mode of dyin	A MA g, such as card	RYLAND 2 liac or respiratory ar	0646 rest,	A	pproximate terval Between
	Physician		Immediate Cause (Final	را حمد	tzfeld-	t - 100	ah a	isease		02	nset and Death
	/Medical		disease or condition resulting in death)		a consequence of):	1 346	00 0	( susc			months
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Вох	death certific e attending p od for use as	an/N	23b. Was decedent pregnant	3c. It yes, outcome 1□Live birth		Ectopic pregnancy	,			ot delivery	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		Other (specify)			Mont	h Da	ıy Year
P.O.	that the de ned by the a detached f	h.	9 Unknown								
	5 5	Completed by Physician/Me	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		bacco use contrib		
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Vital Records	ysiclan: Th is certificete director, peg	Be	25. Was case referred to medical examiner?				26. Place of [	Death (Check only o			404
	× ∞ ō	10	1 Yes 2 No	ospital: 1 🗌 Inpatie	nt 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursin	Home 5 Resid	tence 6 ther	(Specify)	Hospice
Division of	ding Pt h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe h	now injury occurred	d	
.0	Attending r death. ector: After by the fune	atle	2 Accident investigation				Yes 2 □ No				
≝	il or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, sti c. (Specify)	reet, factory, office		28f. Location (5 City or Tox	Street and Number vn, State)	or Rural R	oute Number,
	ital c	S									<u> </u>
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examin	ician: To the best of	of my knowledge, deat examination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ice, and due to the occurred at the time	cause(s) and man	ner as state	ed. e cause(s)
	the Hin 24 the F	Med	one)	and manner sta	ited.						
\	5 th 5 co	~	29b. Signature and title of certifier			29c. Licenso	e unwoer	7	29d. Date signed	Month, Day	y, Year)
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	IU		30. Name and address of person who co	mpleted cause of de		-	72 5	Eute 204	Food	- 75	MN
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ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

Bishop Walsh Road, Cumberland, MD 21502

Healem

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

32. Begistrar's Signature

			For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>			giene Reg. No.	2007	06344
65	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day	Year	3. Time of Death
٠. ن	/Medic Examin		Betty Jane Pie  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Februa		2, 2007 County of Death	12:50a. <sup>™</sup>
	LXdiiiii		Gilcrest Hospice			Towson	,			Baltimor	re
	Funeral Director		5. Social Security Number 289–12–8889 6. S	ex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl 2/3/19	h 2 Ye <i>ar)</i> 2 <b>4</b>	9. Birth Cou West	place (State or Foreign ntry) Virginia
	w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryt -f sho iled al	to	MD Harfo	rd A	berdee	n					1 <b>2</b> Yes 2 □ No
	or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	ath wit	ral	444 Hillcrest Dr				001			S.A.	
30	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify:Whit	etc.
2-003p	2 hou atura ical E		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation during most of work	ing	16b. Ki	nd of Business/Ir	dustry
N	thin 7 ie. ian "n Medi	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retired	during most or work	ng			
7	filed within Hygiene. Ither than "	S	12 17. Father's Name ( <i>First, Middle, Last</i> )	2	Home	maker 	18. Mother's Name	(First Middle		n home	
yland	d be fi	Be c	Homer J. Smith				Mae C	•	waden	ourname)	
2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	٩	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City o	r Town, State, Zi	o Code)
Ž,	and 2 salth a r 27 is er tra	1	Jeffrey R. Piero			Colaine D		rdeen, M			001
baltimore	D O		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	emetery, crei A. Fer	rition (Name of matory or other place ris & Co.	2/24,	07		t Cheste	
pair	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Licer	Muchesko			-Cargo Fur Marylar			399 <sup>A</sup> •	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Schem		wding	opatny			- 1	weeks
	Examiner		- 1	Due to (or as a consequ	uence of):		B) -50				
ļ		ner	Sequentially list conditions, if any, leading to immediate cause. Erret Ungerwing	Due to (or as a consequ	uence of):						
4	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ionac offi						
8/60,	icate be executed physician and s the burial-transit	edical E		d.	defice of).						
0	ing phi		IF FEMALE:								
.O. Box	the death certificate be executed y the attending physician and iched for use as the buriat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 WNo 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (spec <i>ify)</i>	/		2	23d. Date of deliv Month	ery Day Year
7	w requires that the de been signed by the s should be detached		Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
rds	quires en sign uld be	ed by						1 🗆 ነ	Yes 2[	□ No 3 Pro	bably 4 □Unknown
Kecords,	e las has	Completed						24a. Was autop perfo 1∏ Yes		prior to co	opsy findings available ompletion of cause of
Ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	111		Lou	26. Place of Deat				1
0	hys his I dir	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier		4 Li Nursing Ho	me 5 Residence 128d. Describe I		<del></del>	ity) NOSTICE
	iding Phi th. After thi funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200, Describe i	iow injur	y occurred	
Division	after deat after deat Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 290 Place of injury - At he	ome, farm, st	reet, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or Rui	ral Route Number,
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	edical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.	ition and/or ir	nvestigation, in my	opinion, death occur	red at the time,			
	To the within	Me	29b. Signature and title of certifier	ws		29c. Licens	8303 57 AM	-	29d. Dat	te signed (Month	, Day, Year) 2007
_	15		30. Name and address of person who	NES MO 670	n 23a) (Type,	Print) . Charles	ST BALL	nune	mg	21204	
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 20	32 Registrar's Signa	ture &	artis)					

State of Maryland / Department of Health and Mental Hygiene) 06345 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lillian Ransom Feb.11,2007 6:50pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 423-32-3335 Director 78 Oct. 23, 1928 Alabama Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "naturel", or iteme 23a or 28a-f shovite Medical Expenier must be notified at 1 XYes 2 No Director MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 Prairie Court 20774 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H ant: if Item 27 is marked ott Joe Patterson Willie Mae Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) james Ransom / Husband 308 Prairie Court, Upper Marlboro MD 20774 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: if any Injury or once. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Md Veteran Cem. 2/23/07 Crownsville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway, Bowie MD 20715 owe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) ONAR **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Vinknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending death. 1 Tes 2 No 2 Accident investigation the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 82. Registrar's Sig State Registrar

			For State Registrar	State of M	aryland	-	artment of			_	giene Reg. No.	07	06346
*	Dhuelei		1. Decedent's Name (First, Middle, Las	0						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medic		Mary Ra	nsome						02	10	2007	12:04P M
	Examin	er	4a. Facility Name (If not institution, give		)		4b. City, Town		of Death		į,	unty of Death	
100		A	PRINCE GEORGE HO		(1 1-	- 4 t int d - 1	CHEVER If Under 1 Ye		r 24 Hrs.	0.0(0)		NCE GI	
L	Funeral		5. Social Security Number 6. Sec. 125~16~8579	X XX F 7. A	ge (In yrs. la	Yrs.	Months Da		Min.	8. Date of Bird (Month, Da	y, Year)	Cou	place (State or Foreign ntry)
100	Director		Usual Residence of Decedent	1	90					11-22-	1916	NORTH	I CAROLINA
	/land	Ì	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Man a-1 sh	ţo	MD PRINCE GI	EORGE	TEME	PLE HI	LLS						Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Cod	le			10g. Citizen	of What Cou	ntry?
	th will	Funeral Director	2509 KEATING ST				20748	3			U.S.A		
	eep see	ner	11. Marital Status	12. Was Decedent Armed Forces		i. 13. \	Was Decedent	of Hispanic O	rigin? (Spe	ecity Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White	
36	or it	by Fu	1 Never Married 2 Married	1 □ Yes 2 📉 If Yes, Give	No		1 ☐ Yes 200					ecify:BLAC	.K
ğ	ursi',	d b	3 ₩idowed 4 Divorced	Year or Dates:		16a Deser	dent's Usual Oc	aunation.				of Business/Ir	
21215-0036	within 72 hours after deeth with the Maryland ene. then "naturel", or Itams 23a or 28a-f show the Madical Exemiter must be inclibed at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		(Give	kind of work do	ne during mo	st of worki	ng	100. Killa	n Dusinessyn	idustry
7	with the	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	HOII	SEWIFE				PRT	VATE	
D	Hyg other	Bec	17. Father's Name (First, Middle, Last)			1100	D2((1112)	1		(First, Middle,	Maiden Sur		
lan	Ald be Alenta rksd tic sv	To B	WILLIAM HOWELL					ELL	OUISE	E. HOW	IELL		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic avent, the Modical Examinat must be notified at an and.		19a. Informant's Name/Relationship (7				g Address (Str						o Code)
	and 2 palith n 27 i		DESIREE PARKER/DAU	JGHTER 		-	KEATING			and the same of the			
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	1 00	ace of Dispo metery, cren	sition (Name of natory or other	place)		ate	20c. Locati	on - City or T	own, State
<u>=</u>	Pag Iment tant:		4 Donation 5 Other (Specify	)	FAM	ILY PI				-2007			
39	Deporting Important in conce.		21. Signature of Funeral Service Licen	500	7		. Name and Ad						ME
	70 = 4 Q	-	2- D. M-	-hall	od the death		474 LAN					0785	Approximate
2	Dhysisian		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final								11631,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Que to (or as	O M Q I		Hery		sea.	عد			Many Yes
	Examiner		Conventially list conditions	Dra	bete	s Ty	PeI						Many yes
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
3760,	ate be executed hysician and the burial-transit		losaring in doubly East	Due to (or as	s a conseque	erice or):							
687	physic the t	dical		d									
×	ding se as	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnan	псу					23d	Date of deliv	erv
Вох	etter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			Ectopic pregna Other (specify				200.	Month	Day Year
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	The law requires that the death certifics ate has been signed by the ettending phoage 2 should be detached for use as it	by P	Part II. Other significant conditions conditions								obacco use	contribute to t	the cause of death?
Vital Records,	w require been sig should b	ed	Pressure So	rascula.	Di	seas	e, ,		· ·	1 []	Yes 2□N	o 3 Pro	bably 4 □Unknown
ecc	law reas be	Completed	Pressure So	res, De	emen	, 414	, OSY	coart	4-575		osy	prior to co	opsy findings available ompletion of cause of
œ —		5	Gout							perfo	2 No	death? 1 ☐ Yes	2 □ No
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?						ce of Death	(Check only o	one)		
5	Physic this c	မ	TEL TES ZEINO	Hospital: 1 Impat			IL SULLOA			me 5 ☐ Resi			fy)
Division of	Attending Physician: The lav r death. ector: Atter this certificate has by the funeral director, page 2	Ö	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ay Year)	28b. Time of Injury		njury at Work? 1 ☐ Yes 2 [		28d. Describe l	now injury oc	currea	
isi	death death ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be		niury - At hor	me. farm. str				28f. Location (	Street and N	umber or Rur	al Route Number,
<u>≤</u>	after after Dire	Certification:	4 Homicide determined	building, e	itc. (Specify)	) -,,			•	City or To			
	To the Hospital or Attant Within 24 hours after death To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my know of examinati	vledge, death	occurred at the	e time, date a	and place,	and due to the	cause(s) and	d manner as s	stated.
	To the F To the F Complete	Medi	one)  29b. Signature and the of conflier	and manner s	tated.			ense number				gned (Month,	411
1	2 2 2 5		Soc. Signature and the Or Common	127	Mi			D3/				1/2/	
	(3)		30 Name and address of nerson who	completed was of	death (Item	23a) (Tyne	Print) Z	006	-00	7000	CATI		#430
	THE		30. Name and address of person who and address of person who are the state of the s	kear; t	3,41	> (1) pa.	Gr	een	belk	MIS	50.	770	ELS.
	Sta Regist	ate rar	FEB 16 2007 Year)	32. Regis	trar's Signati	Ura/							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:58 P February 2007 Richard Ramsey Rankin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 8608 Wandering Fox Trail Odenton 8. Date of Birth (Month, Day, Year) Mar. 27,1939 If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** Months Hours 1**∑**M 2□F Yrs. West 67 212-38-5061 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other trsumatic event. The Medical Examiner roust be nutified at 1 □XYes 2 □ No Anne Arundel Odenton Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 21113 USA 8608 Wandering Fox Trail Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1962–64 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oe filed with the her then "r College (1-4or 5+) Elementary/Secondary (0-12) Auto dealership Service Manager 12 and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be Russell Rankin Clara Bishop ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Item 27 8608 Wandering Fox Trail Odenton, MD. Theresa B. Rankin / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
ony injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 02/16/2007 Brentwood, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowle, MD 20715 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CITIL CANCER OF HERO TYVECK 27RS 5 mos Saugmius **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Box 68750, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9☐ Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1€Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed? page certificate 1□ Yes 2☑No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner Teath 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Effatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Within 24 hours after death To the Funeral Director: Completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the 29c. License number 29b. Signature and the of cert 2 VIVI TYTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) varios mozigas KINSUN 700 STANUET U FEB 16 2007 32. Registrar's Sigoature State

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Registrar

Certificate of Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28s-1 show and enyel, the Medical Examiner rout be notified as 19 in	Baltimore, Maryland 21215-0036			
- a o	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. International them 23 is marked other than "natural" or Itame 23s or 28s-1 ehow eny injury or other treumatic event, the Medical Examiner must be notified as	Funera Directo	Exam	/Mec

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 17, 2007 Dorothy Evelyn ROZIER 12:02 p. cal 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ner Autumn Assisted Living Washington Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🖔 F 93 Yrs. 299-01-8983 Ohio Sept. 14,1913 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Washington Hagerstown Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 310 Cameo Drive 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) bookkeeper/self-employed bookkeeping 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Moatz Edith Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Rozier - son P. O. Box 340E, Jordan, Michigan 49727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 2/19/07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -3 drys /Medical Due to (or as a consequence of) Examiner DRIDARY LAFECTION TRACT Caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest are the cause) Due to (or as a constituence of) or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ARBIOVASE 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DEMENTIN 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA ၉ 1 ☐ Yes 2 ☐ No #Pis LIVIDE After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 -Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death | Director: / d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel C completely filled i 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier cati mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05H-3

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Day Year) 2007



HAGERSTOWN MA 21740

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			1 _ State	eartment of Health and M Prtificate of Death	2007	0621.0
E.g	at a	di.	Registrar  1. Decedent's Name (First, Middle, Last)	Timcale of Dealif	Reg. No.	3. Time of Death
	Physici /Medic		William Cleveland Ruth	•	Wonth Day Year 10 2007	5:26 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
		2	Washington County Hospital	Hagerstown	Washingt	
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	(Month, Day, rear) Col	place (State or Foreign intry)
	Director		Usual Residence of Decedent		March 29 1917 Mar	yland
	yland now		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	e Mar	ctor	Maryland Washington Hagersto	wn		1 □Yes 2 XNo
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?
	s 23a nust	eral	21507 Kelso Drive	21742	U.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I  1 ☐ Yes 2 ☐ No Specify:	Specify:	, etc.
5-0036	2 hou atura cal E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/h	ite ndustry
2	thin 7	ple	(Specify only highest grade completed) (Giv	e kind of work done during most of workin DO NOT use retired)	g	,
2121	filed wit Hygien other the	Completed	8 Meta	l Fabricator	Metal Fab	rication
aryland	be file Ital Hy d oth event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surname)	
<u>₹</u>	2 should be and Mental is marked o	오	Grover Cleveland Ruth		by Brown	
ā	nd 2 shalth and 27 is n		19a. Informant's Name/Relationship (Type. Print) 19b. Mai Nancy Diane Martz / Daughter 2150	ing Address (Street and Number or Rura	Route Number, City or Town, State, Zierstown Maryland 2	
<u>(</u>	the the		20a. Method of Disposition 20b. Place of Disp	osition (Name of D	ate 20c. Location - City or T	
ltimore,			Durial 2   Cremation 3   Removal from State	ematory or other place) en Cemetery 2/19/2		
altir	permit, Page Department of Important: If any injury or once.		21. Sign for of Funeral Service Livensee	22. Name and Address of Facility Res	2007   Hagerstown,	Maryland
m	Der imp		1 7 2 m	601 Pennsylvania A	ve Hagerstown Marv	land 21742
R	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting In death)  a. Due to (or as a consequence of):			1 math
	Examiner		a chance dol	mai sulm	- anian	unknown
	₽ .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury			
	ecute and trans	Examiner	that initiated events c.			
60,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):			
68760,		edical	d			
_	law requires that the death certificate tas been signed by the attending physic should be detached for use as the L		IF FEMALE: 23c. If yes, outcome pf pregnancy		23d. Date of deliv	rerv
. Box	death e atte d for	Physician/M	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month	Day Year
Р О	at the de by the a tached	hys	9 Unknown 9 Unknown			
s,	w requires that been signed E should be dete	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to t	the cause of death?
or D	requir sen si nould		Algheimen Denen		1 Yes 2 No 3 Pro	bably 4 🖽 Known
ě	law las b	Completed			autopsy prior to co	opsy findings available empletion of cause of
Vital Records,	: The l	Con			performed? death? 1□ Yes 2□Ho 1□ Yes	
	slcian: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death Other:		
ō	Phys r this ral dii	-1 -1	1 ☐ Yes 2 ☐ Ho ☐ Hospital: 1 ☐ Hipatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	AL Nursing Hon	e 5 Residence 6 Other (Speci	fy)
o	rding th. : Afte s fune	tion	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at 2 Work?  M 1 ☐ Yes 2 ☐ No	d. Describe now rijury occurred	
Division	Atter r dea ector by the	ifica	3 Sulicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	Bf. Location (Street and Number or Run	al Route Number,
	tal or s afte al Dir	Certification:	a Dullulity, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical (	29a. Certifier (Check only (Ch	th occurred at the time, date and place, a	nd due to the cause(s) and manner as s	stated.
	the I hin 24 the F mplete	Medi	and manner stated.	29c. License number		
	7 wit	-	29b. Signature and title of certifier	29C. License number	29d. Date signed (Month,	
,					FEB 17.2	_ 0 , )
6	H- 4+1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	ERSTOWN ME	21740
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr		FEB 2 0 2007	Table 1		

DHMH 17 Rev 1/2001

			State of N  State of N  Registrar		partment of Health and Mertificate of Death	ental Hygie	- / 1111 /	06350
1			negistrar     Decedent's Name (First, Middle, Last)			2. Date of Death	_	3. Time of Death
	Physicia	_	Hester Louise Reimer			Month February	11, 2007	4:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	7)	4b. City, Town, or Location of Death		4c. County of Death	
			11776 Ridgeway Court		Monrovia		Frederic	1
14. ·	Funeral		1 M 2 T F	Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 13,	9. Birth	place (State or Foreign intry)
No. 14	Director		014-20-0788 Usual Residence of Decedent	80 113.		066. 13,	1926 <sub>Mass</sub>	achusetts
	land ow		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Man a-f sh filed	tor	Maryland Frederick	Monrovia				1 ☐ Yes A No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
	ath wi	ral	11776 Ridgeway Court		21770	US		iaga Indian
	er deg	nue	11. Marital Status 12. Was Deceder Armed Force:		<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	14. Race - Amer Black, White	
30	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates	-	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Marylan dal Hygiene.  I del Hygiene.  I defer than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education	16a. De	cedent's Usual Occupation	161	b. Kind of Business/I	
2	hin 7. 9. An "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4o	r 5+)	ive kind of work done during most of worki e. DO NOT use retired)	ng		
7	er tha	Con	2	Regi	stered Nurse		althcare	
	Id be filed within 72 hours after death with the Maryland lental Hygiene. **Red other than "natural", or items 23a or 28a-f show keed other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Mai	den Surname)	
<u> </u>	nould A Mer narke natic	ှင	John A. Ward  19a. Informant's Name/Relationship (Type. Print)	19h M	Daisie Co ailing Address (Street and Number or Rura		ity or Town State 7	in Code)
Maryland	d 2 sl th and 7 is r traur		Stephen Reimer/son	1	O Foxville Rd. Sabi			
ō,	tem 2	1 2	20a. Method of Disposition	20b. Place of Dir	sposition (Name of Errematory or other place)	Date 200	c. Location - City or 1	fown, State
ē	ages ent of nt: If i		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te	ake Crematory 02/1	3/07 Be	ltsville,	MD
Baitimore,	permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: If item 27 is marked other it any injury or other traumatic event, the once.	1	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Going Home Crematio			
ñ	a m De		Donals LHellh					
-6	4		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not line.	enter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
eq.	Physician		Immediate Cause (Final disease or condition	Multi	ple myeloma			years
	/Medical Examiner		resulting in death)  Due to (or a	as a consequence of):	. V			1
	LAdillillei	<u>_</u>	Sequentially list conditions, b.	as a consequence of):				
-	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	,				
	execu n and al-tra	Exar	that initiated events c.	as a consequence of):				
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9	rtificat ng phy as th	/ledi	IE EEMALE:					-
O. Box	th cer tendir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth		3 □Ectopic pregnancy		23d. Date of deli	very Day Year
	e dea he at hed fo	sici	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 Other (specify)		Monar	54,
<u>.</u>	hat th d by t fetach	Phy	Part II. Other significant conditions contributing to death	but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	signe signe	l by	coronan arte	, "	ease	1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Ö	v requ	Completed	time 2 Nichard	tes melli	tus	24a. Was an	24h. Were au	topsy findings available
ž	he lav e has ge 2	Id m	Tape 2 olase	ic >   Cier	102	autopsy performe	prior to death?	completion of cause of
g	ifficate or, pa		25. Was case referred to medical		26. Place of Deat	1 Yes 2 h (Check only one)	No 1 ☐ Yes	2 No
>	ysicia is cert direct	o Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	atient 2 ☐ ER/Outpa	Othor	10	ce 6 🗆 Other (Spec	cify)
Division or Vital	ig Ph ter th neral	T:U	27. Manner of Death 28a. Date of I	njury 28b. Tim Day Year) Inju		28d. Describe how	injury occurred	
<u> </u>	endir ath. or; Af he fur	atio	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Ĕ	or Att ter de virect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	injury - At home, farm, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	pital ours at eral C		29a. Certifier 1 Certifying Physician: To the be	est of my knowledge d	eath occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  2 Medical Examiner: On the basione)	s of examination and/o	or investigation, in my opinion, death occur	red at the time, date	e and place, and due	to the cause(s)
	ro the vithin ro the complex	Me	29b. Signature and title of certifier	1	29c. License number	29d	. Date signed (Month	n, Day, Year)
	->-0		1 al Ha	/ ND	D53120	7	2/12	107
1	5 8.6		30. Name and address of person who completed cause of		pe, Print) arex ct fred	erick	NO.	21703
	Sta	ite		istrar's Signature				
	Regist		LED TO 5001	en li	Sperke			

			1 - For State Registrar	State of Marylan	d / Depa	artme		ealth and i	Mental Hyg	_	07 06351
100	Physici /Medic		1. Decedent's Name (First, Middle, Last)	. Ramsburg					2. Date of Dea Month FEB	th Day	3. Time of Death 2007 0218 M
	Examin		4a. Facility Name (If not institution, give st			4b. City	, Town, or 3ALT	Location of Deat	h	4c. County	
	Funeral Director		5. Social Security Number 6. Sex 220 24 0532  Usual Residence of Decedent	7. Age ( <i>In yr</i> s. 80	iast birthday) Yrs.	If Und Months	er 1 Year Days	Hours Min.	8. Date of Birth (Month, Day July 15	, Year)	9. Birthplace (State or Foreign Country) Maryland
	the Maryland 28a-f ehow notified at	rector	10a. State 10b. County  MD Howard  10e. Street and Number		y, Town or Lo	a	ip Code			10g. Citizen of \	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with	i D	10560 Shaker Drive				1046				d States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	i		edent of His edify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		ce - American Indian, ck, White, etc.
Maryland 21215-0036	ithin 72 ho 16. han "natu	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life.	kind of w	ual Occupa rork done d use retired)	uring most of wo	rking	16b. Kind of B	usiness/Industry
Z   D	Hygier Hygier Ither th		12 17. Father's Name (First, Middle, Last)		I	nsta	ller	18. Mother's Nar	me (First, Middle,		phone Co.
Ilan	Mental Mental rrked o	To Be	Clavin Ross Ramsbur	ā			:	Sadie Bu			
Man	12 sho h and h ls ma rauma		19a. Informant's Name/Relationship (Typ		1				ural Route Numbe		
	Health tsm 27 other tr		Hattie J. Ramsburg/ 20a. Method of Disposition		1056 Place of Dispo semetery, crer	0 Sha	aker l	Drive Co	olumbia, Date		16 City or Town, State
altimore,	Pages nent of I ant: If its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	IIIOATI IIOIII SITIA				1	.6-2007	Marriot	tsville, MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses	-Why MO10							s Family FH Inc City, MD 21043
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that bused the deat e cause on each line.  Due to (or as a conseq		er the mo	ode of dying		epsi		Approximate Interval Between Onset and Death
8760,	te be executed ysicien and le burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or a))).							
P.O. Box 68	The law requires that the death certificate be executed at has been signed by the attending physicien and bage 2 should be detached for use as the burial-traneth	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant al time of d 9 □ Unknown	ıl death 3 [	⊒Ectopic ] Other (:	pregnancy specify)				ate of delivery onth Day Year
rds, P	w requires that been signed b should be deta	ed by P	Part II. Other significant conditions cont	nbuting to death but not res	ulting in the u	nderlying	cause give	n in Part I.			Inbute to the cause of death?  3 ☐ Probably 4 ☐Unknown
Vital Records,	: The law recate has be	Completed by							24a. Was a autop perfor	sy med?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 1 Ho
<u>=</u>	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Un patient 2	I FRIO		Othe	ar.	ath Check only or		
DIVISION OF	To the Hospital or Attending Physician: The law within 24 hours after deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	27. Manner   eath 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	at at	dome 5 Resid		
DIVIS	o Hospital or Attending I 24 hours after deeth. • Funeral Director: After etely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - AI h- building, etc. (Specil	ome, farm, str	reet, facto	ory, office		28f. Location (S City or Tow	treet and Numb n, State)	per or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I	Medical	one 2 Medical Examin	cian: To the hest of my kno er: On the basis of examina and manner stated.	owledge, deal ation and/or in	n occurre vestigation	d at the tim on, in my op	e data and plane inion, death occu	and due to the curred at the time, c	tuee(s) and madate and place,	anner as stated. and due to the cause(s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	L AAMIR CHEEMA	M.D		9c. License			_	d (Month, Day, Year)
(0	(a)		30. Name and a dress of person who cor	npleted cause of death (Iter	n 23a) (Type,	Print)	THM	0630.	EEMA	FEB .	13 2007
	/ ·	10	5/24 STONE ST, 31. Date filed (Month, Day, Year)	10 P CIRC  32. Begistrar's Signa	LE /	, ON	1114695	MILL	5, 111)	2	111/
1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	Sta Registi		FFB 1.5 201	7 Besses	K A	Para M	,				

DHMH 17 Rev 1/2001

		1	For	ate of Maryland / [				-	1	07	06	352
	Physicia	an .	1. Decedent's Name (First, Middle, Last)	Katherine		ROSIER		2. Date of Dea Month 02	Day	Year 07	3. Time of 5:20	of Death  A • M
	/Medic Examin				4							
					irthday)			8. Date of Birth	,			or Foreian
	Funeral Director		233-44-7420 ¹□M :				Hours Min.	Nov. 18	1918 1918	Mary	yland	
	w .	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	wn or Loca	ation					10d. Inside (	City Limits
	Maryl: -f sho fied at	tor	MD. Garrett	Bloo	oming	gton					1 <b>XX</b> Ye	s 2∐No
	3a or 28a st be noti	al Direc	10e. Street and Number 152 Pattison Ave	•		10f. Zip Code 21523						
036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show iteal Examiner must be notified at	by	1 Never Married 2 Married 1	rmed Forces? □Yes 257No			spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bla	ck, White	etc.	
21215-0036	"natural",	leted	15. Decedent's Education (Specify only highest grade con		a. Decede (Give ki	nt's Usual Occupa ind of work done do	ition uring most of work	king				
121	within iene. than " the Med	dmo	Elementary/Secondary (0-12) Cunknown	ollege (1-4or 5+)					Paper	Manu	tactur	er
and 2		Be	17. Father's Name (First, Middle, Last)  Tom McDowell						Maiden Surna	me)		
Maryland	12 sho h and 7 is m traum	F										
Baltimore,	Page ent o ht: If		20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □ Remore 4 □ Donation 5 □ Other (Specify)	cemete	tery, crema	atory or other place						l
Balti	permit. Pac Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	Bel			150				2156	52
1	4	To Register Post Methods Last)  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Katherine  EVA Form or successor of beach  CUMBERLAND  ALLEGANY  Method Days House or successor of beach  EVA Method Days House or Successor of beach  EVA Method Days House or Successor of beach  EVA Method Days House or Successor of beach  EVA Method Days House or Successor of beach  EVA Method Days House or Successor or Successor of beach  EVA Method Days House or Successor			Approxima	ate letween						
	Physician	Ŷ.	disease or condition	ardio pu	luc	nay	arre	5/			Onset and	
	/Medical Examiner			Due to (or as a confequence	e of):	Cherry 7	2,6	ease				
	* * *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of	0 4.	101		11/	, ,	1	
	ecuted nd transit	ami	Cause (Disease or injury that initiated events	giately	an	d org	perfece.	Long	- Hyp	Mejo	Rolle	4
68760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	e of):	//			//			
687	ifficate g phys as the	edic	d									
D. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	/siclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	l □Live birth 2 □ Fetal deat l □Pregnant at time of death								Year
ds, P.0	uires that the signed by Id be detac	20	Part II. Other significant conditions contribu		in the und	deriving cause give	en in Part I.		<u>ا</u>			
Records,	ne law req e has been ge 2 shoul	mplete	( Acuk Perl	al failur	l -	. Oeij	uric	autor	osy	prior to c death?	ompletion of	s available cause of
ta	an: Ti tificate tor, pa		25. Was case referred to medical				26. Place of Dea			1 L Yes	2 LI NO	
or Vital	lysicia lis cer direct	O B	examiner? 1 Yes 2 No	ital: 1 Inpatient 2 ☐ ER/C	Outpatient	3□ DOA Othe	er: 4 🗆 Nursing H	ome 5 ☐ Resid	dence 6 □O	ther (Spec	cify)	
o uo	Attending Ph r death. ector: After th by the funeral		1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year) 28b.				28d. Describe	now injury occu	urred		
Division	I or Atter after deal Director	ertifica	3 Suicide 6 Could not be 2	8e. Place of injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (3 City or Tov	Street and Nun vn, State)	nber or Ru	ral Route Nu	umber,
	e Hospita 24 hours e Funeral letely filled	dical C	(Check only 2 Medical Examiner:	On the basis of examination a	lge, death and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	manner as e, and due	stated. to the cause	e(s)
	To the vithin To the complete complete the c	Me	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date sign	ned (Month	n, Day, Year,	)
	3		dell ely	x My		D13	601		2-1	3-0	57	
			30. Name and address of person who compl	eted gause of death (Item 23a	a) (Type, P	Print)	WAISH	Road.	Cumh	perlo	and i	21502 MO
	St Regist		31. Date filed (Month, Day, Year) FEB 1 5 200	32. Registrar's Signature					tun			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Physician RIGGS 8 11:40 A M **JOHN** FEB. CHAMBERS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **QUEEN ANNE** CHURCH HILL 220 MERRICK CORNER ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Yrs. JULY 25, INDÍANA Director 62 1944 213-44-0165 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at CHURCH HILL 1 ☐ Yes 2 No Funeral Director **QUEEN ANNE** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 220 MERRICK CORNER ROAD 21623 r deeth v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 M2 Yes 2 □ No If Yes, Give Year or Dates: 1964–1970 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FARM EQUIPMENT MECHANIC 12 -0of Health and Mental Hygie filtem 27 is marked other r other treumatic svent, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM B. RIGGS, JR. FLORENCE WYLDER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 220 MERRICK CORNER ROAD, CHURCH HILL, MD 21623 SHIRLEY T. RIGGS/ WIFE Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other of Date 20c. Location - City or Town, State 20a, Method of Disposition ō = 6 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 2-12-2007 | CHURCH HILL, MD CHURCH HILL CEMETERY permit. Page Department Important: If any injury o 4 Donation 5 □ Other (Specify) 21. Signature of Junetal Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Compared to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Ju 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

James

31. Date filed (Month, Day, Year)

32 Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Viola R. Richel February 11:30 PM 13 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing & Rehabilitation Ctr. Berlin Worcester 8. Date of Birth (Month, Day, Ye July 29, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 923 Massachusetts Months Days Hours 1 □ M 2 👿 F 220-12-9338 83 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1√XYes 2 □ No Director MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 11310 Atlantic Blvd., 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2X No à 3X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the M Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Cirelli Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 147 Old Wharf Rd., Ocean City, Md. 21842 John W. Wood (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-15-2007 Henlopen crem. | Frankford, DE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, Md. in polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ity one cruis, on each line. Part1. Enter the disease shock, or heart failure Approximate Interval Betw Immediate Cause (Final and was culo **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or; Examine be executed burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 No certificate Yes or Attending Physician: 25. Was case referred to medical examiner? director 26 Place of Death (Check only one Certification: To Be Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No iours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours a To the Funeral I Fo the Hospital 3A3

State Registrar 31. Date filed (Month, Day, Year) 2007

29b. Signature and title of certifier

strar's Signature

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

07-01163
Jairus Robinson
Dhuminia

'-01163 irus Robinson		Please Type or Print in Black Indelible State of Maryland / Departmen			ble.	0635		
		- For State Certificate	, ,	Reg. No				
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death		
edical Exami	ner	Jairus Andrew /	Robinson	Month D February 11	ay Year , 2007	1756 hrs		
		4a. Facility Name (if not institution, give street and number)  Dorchester General Hospital	4b. City, Town, or Location of Deat Cambridge	n	4c. County of Death  Dorchester			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hr	s 8. Date of Birth(	MM/DD/YYYY) 9. Birth			
Director		U87-88-6736 1 MM 2 F 8	Yrs. Months Days Hours Mil	April 14	1998 Foreign Cou	ntry) Germany		
any	-	10a. State 10b. County 10c. City, Town or	ocation			10d Inside City Limits		
Maryland 28a-f show d at once.	اۃ	MD Dorchester Can	1bridge			1 Yes 2 No		
daryland 28a-f shov 1 at once.	ect	10e. Street and Number	10f. Zip eode	10g.	Citizen of What Count	ry?		
ith the h	اة	106 Teal Lane	21613		USA			
Den with	era		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	an Indian, Black,		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	1 Yes 2 No		. ,		- 01		
hours afte 'natural'', Examiner	2	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Dec	Yes 2 No specify: edent's Usual Occupation (Give kind of	work done	Specify: Blooms Specify: Bloom	dustry		
2 hour	Completed		ng most of working life. DO NOT use re		lementar			
5-0036 led within 72 Hygiene. other than the Medical	휌		Student		School	*		
5-00 ed wit fygien other be Me	녌	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Mai				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Jerome Preston Robinson	JR. Jeni		ella St			
→ 5 P S = 1	유	19a Informant's Name/Relationship (Type, Print )	Mailing Address (Street and Number or			Zip Code)		
e, MD 2 l and 2 show Health and l item 27 is r	J		6 Teal Lane Ca.	Mbridge Date 12	Marylan	d 2/6/3		
W		1 Rurial 2 Cramation 3 Removal from State crematory	or other place)		oc. Loodion ony or .	, 1		
imore Pages   Iment of Fant: If it	- 1	4 Donation 5 Other Specify: Vetera	ns Cemetery 2/	20/07 /	turlock, M	aryland		
Baltimor permit Pages Department of Important: If		21. Signature of Funeral Service Licensee	22. Name and Address o Facility HENRY FUNERAL H	ome, P.A.		b 2 (( 12		
	-4	23a. Firt I. Enter the disease, or complications that caused the death. Do not e	1 510 Washington	u Stican	shock or land	D. 2/6/3 Approximate Interval		
Physician /Medical	- I	failure List only one cause on each line.			1000000	Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):						
and the second		Sequentially list conditions, b						
	Je.	of any, leading to immediate Due to (or as a consequence of):						
-	aminer	C. Due to (or as a consequence of):		-				
ecuted and transit	Ä	d.						
eve an a	iŝ	UNPENDED AMENDED						
'60, zate be physic he bur	Sec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of delivery			
Box 68760, death certificate be eve the attending physician a df for use as the burial	sician/Medical	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	ancy	Month Da	ay Year		
Sox 6 leath ce e attend for use	sic	1 Yes 2 No 9 Unknown Pregnant at time of death 5	Other (Specify)					
that the de ned by the detached f	by Phys	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?		
P.O.				1 Yes	2 V No 3 Proba	bly 4 Unknown		
ords, w requir s been s should	Completed			24a. Was an autopsy		ppsy findings available mpletion of cause of		
e law e has l	립		<del></del>	performe	ed? death?			
tal Rec cian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check		1 163	2 110		
Division of Vital Records, tal or Attending Physician: The law requirers after cleath  al Director: After this certificate has been siled in by the funeral director, page 2 should be	o Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outp	Othor		sidence 6 Other:			
n of Vi ding Physi After this funeral dir	Η,	27 Manner of Death 28a Date of Injury 28b Tim	ne of Injury 28c. Injury at Work?	28d Describe hov	v injury occurred	to cold water		
ion tendin eath the fur	ţi	1 Natural 5 Pending FO(Mnth: Day, Year) FOUNI Powerington 1555 h	1 163 2 4 110	Subject drown	ed and exposed	to cold water		
ivisior or Attendafter death Director:	lica	2 Accident Investigation Feb 11, 2007   1555 in 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f. Location (Street or Town, State	eet and Number or Rur	al Route Number City		
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determined (Specify) Pond		Hudson Road, C	ambridge, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	d due to the cause(s	s) and manner as state	d.		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner; On the basis of examination and/or investigated						
	Σ	29b. Signature and title of certifier	29c License number		9d. Date signed (Mon.			
		Tall Un - Tollet MS	O.C.IVI.E.	O.C.M.E. February 12, 2007				
		30. Name and address of person who completed cause of death (Item 23a)	er 111 Penn Street Raltimo	re MD 21201				

State 31. Date filed (Month, Day, Year) istrar FEB 15 2007 DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Aaron Robinson	Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	
Auton Robinson	1- For State Certificate of Death	2001 00000
Physician	1. Decedent's Name (First, Middle,Last)  2. Date of	
Medical Examine	Aaron Devon Robinson Febru	ary 11, 2007 Year 1753 hrs
<i>)</i>	4a. Facility Name (if not institution, give street and number)  Dorchester General Hospital  4b. City, Town, or Location of Death  Cambridge	4c. County of Death  Dorchester
Funeral		of Birth (MM/DD/YYYY) 9 Birthplace (State or
Director	022.78-777/ 12M 2 F /2 Yrs. Months Days Hours Min. No.	1,29,1994 Foreign Mass, Country)
>-	Usual Residence of Decedent  10a. State	
e e e		10d. Inside City Limits
the Maryland a or 28a-f show tified at once.	MD Dorchester Cambridge	10g. Citizen of What Country?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	106 Teal Lane 21613	USA
r death with or items 23, insist be no	11. Marital Status 1 Vever Married 2 Married 1 Verified 1 Verified 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married	
Figure 15		
hours afte "natural", Examiner	or Dates:	Specify: Black  16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life. DO NOT use retired)	Middle
within signer that Medi	Student  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	School
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica Be Comple	Tename Prestan Robinson Te Tenaise A	
212 tould b d Ment s mark tic ever	19a. Informant's Name/Relationship (Type, Print )  19b. Mailin Address (Street and Number or Rural Rout	e Number, City or Town, State, Zip Code)
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and 18 should be filed within 72 hours after death with the Maryland tenth 71 s marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Finneral Director	Jerome Preston Robinson 106 tent Lane Cambr	idge, Maryland 21613
TOFE, ages   ar nt of Hez nt: If ite other tr	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
트 를 를 들 등	4 Donation 5 Other Specify. Veterans Cemetery 2/20/0  21. Signature of Funeral Service Licensee 22. Name and Address of Ficility	7 Hurlock, Maryland
Balti permit Departr Import injury	Menous inversa Hon	10, P.A.
Physician	Tavelle C. Hewry 510 Washington St.  23a. Fart I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as fardiac or respirator failure. List only one cause on each line.	ry arrest, shock, or he it
/Medical Examiner	Immediate Cause (Final disease a. Drowning and hypothermia	Death
and the second	or condition resulting in death)  Due to (or as a consequence of):	
n n	Sequentially list conditions, if any, leading to immediate	
ted nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
executed an and all transi		
	UNPENDED AMENDED	
Box 68760, a death certificate be the attending physici ed for use as the burn buxsician/Med.	F FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
OX 6 ath cer attendi	pest 12 months?  4 Pregnant at time of death 5 Other (Specify)	
by the ched fiched f	E a Ouklowii	Did tobacco use contribute to the cause of death?
P.O. es that the igned by be detact		Yes 2 V No 3 Probably 4 Unknown
rds, requir	24a.	Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
He law ate has age 2 s		performed? death? Yes 2 ✔ No 1 Yes 2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring editinal Certification: To Be Completed by Physician/Medical	25. Was case referred to medical 26. Place of Death (Check only one)	
f Vit Physic or this	O 1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Start Nursing Home	Residence 6 Other:
	27. Manner of Death  28a. Date of Injury 1 Natural 5 Pending  28a. Date of Injury FOWND: 28b. Time of Injury 1 Yes 2 No  28d. Desc. Subject 1 Yes 2 No	drowned and exposed to cold water
IVISIOR or Attendather death Director: 1 in by the	2 V Accident Investigation Feb 11, 2007 1555 hrs S Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	tion (Street and Number or Rural Route Number, City
Division o spital or Attending rours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify) Pond or To Hudson I	wn, State) Road, Cambridge, MD
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		e cause(s) and manner as stated.
To the Ho within 24 To the Fu complete)	29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	D-t O.C.M.E.	February 12, 2007
	30. Name and address of person who completed cause of death (Item 23a)	
8 <b>9</b> K	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201
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Registra		
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			For State Registrar	State of Ma	aryland / De		t of H	ealth and	•	giene Reg. No.	07	06357
		2 4	1. Decedent's Name (First, Middle, Last						2. Date of D	eath		3. Time of Death
	Physici /Medic		Rosa Elnora	Ratcli	ft				FEBRUAR'	Y 10 20	Year 107	09:50 P M
2	Examir	er	4a. Fecility Name (If not institution, give			4b. City,	Town, or	Location of Dea	th	4c. County	of Death	
			WICOMICO NURSING HOM  5. Social Security Number 6. Se		(In yrs. last birthda	SALIS If Under		If Under 24 Hr	0 0 0 ( 0 :	WICOM		
	Funeral Director			м 28 г 93	Yrs.	Months	Days	Hours Mir		/1913	9. Birthing Cour Mary	place (State or Foreign htry) yland
	land ow		10a. State 10b. County		10c. City, Town or	Location				-	1	Od. Inside City Limits
	Many Many Illied	ţċ	Maryland Wicomic	00	Salis	bury						1 <b>_</b> Wes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinat must be notified at angles.	Completed by Funeral Director	10e. Street and Number 900 Booth St.			10f. Zip	Code 21801			10g. Citizen of USA	What Cour	ntry?
	ems a	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 1:	3. Was Deced	ent of His	panic Origin? (	Specify Yes or Norto Rican, etc.)	0- 14. Rac	e - Americ	
9800	ours after ral', or it	d by Fu	1 Never Married 2 Married 3 W Widowed 4 Divorced	1 ☐ Yes 2 🕱 N If Yes, Give Year or Dates:	0	1 🗆 Yes 2		Specify:	ito vitouri, oto.,		/: whi	
21215-0036	ithin 72 h ie. ian "natu	nplete	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5-	(Gi	cedent's Usua ve kind of won . DO NOT us	l Occupat k done du e retired)	tion uring most of we	orking	16b. Kind of B	usiness/Ind	dustry
	led willygien her th	Con	3	0	Nur	ses Ai				Nursi		mes
Maryland	buld be fi Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Last)  Marion E. Ludnum						sinclai	n, Maiden Suman L	10)	
	and 2 sho salth and 1 27 Is m er traum		19a. Informant's Name/Relationship (Ty Marion K. Ratcliff	pe, Print) Son	19b. Ma 14	iling Address 13 Schu	(Street ar 11tz	Dr., Fr	ural Route Numb uitland,	MD 218	State, Zip 26	Code)
Baltimore,	ges 1: t of He If Item or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dis cemetery, c Springr	position (Nam ematory or oti	e of her place	)	Date	20c. Location -	City or To	wn, State
ţ	t. Partmen		'4 □Donation 5 □Other (Specify)		Garder	s		2/1	4/07	Hebro		
Bal	permi Depa Impo any Ir	. (	21 St nature of Funeral Service Licens		CFSP	Hollow	ay	uneral	Home Pro	fession	al As	sociation
	Physician //Medical Examiner  the pright transit	Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate result in the disease or injury that initiated events resulting in death) Last	Due to (or as a	o.  Consequence of):	nter the mode		such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3	B⊟Ectopic pre				23d. Dat	e of delive	ry Day Year
ds, P.	uires that signed by	by	Part II. Other significant conditions con	stributing to death bu	t not resulting in the	underlying ca	use giver	in Part I.				e cause of death?
Ĕ,	The ate has page	Completed							24a. Was autor perfo 1  Yes	osy primed?	Vere autor prior to con leath?	osy findings available appletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:					ath (Check only o			
of	ding Ph h. After th funeral	atlon: To	1 Yes 2 No Can N	1 Linpatien	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Month, Day Year)  28c. Injury at Work? M 1 Yes 2 No					)		
Division	i i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, s (Specify)	street, factory,	office		28f. Location (3 City or Tox	Street and Number vn, State)	er or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Certifying Physical Examination)	sician: To the best of ner: On the basis of and manner stat	examination and/or	ath occurred a investigation, i	t the time in my opir	, date and place nion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as sta ind due to	ated. the cause(s)
	To t To tl	×	29b. Signature and title of certifier				License i			29d. Date signed	(Month, E	Day, Year)
	CB		1 yrell	l.		- 1	) 00	6319	9.	02/12/	-60	
1	4		30. Name and iddress of person who co MAESHA THIMMARAYAPPA		ath (Item 23a) (Type EASTERNSHOR	,	SALI	SBURY. Mr	21804			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature			-20, 116				
1 1 2	Registr	alf	FEB 1 4 2	JUI MARCH	w K	( Darke	,					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥬 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Betty Wilkinson Renn 22, February 2007 0740 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Sunrise Assisted Living Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director 176-20-7286 OCT 31. 80 1926 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Hygiene. uther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Norman Allen Street 21921 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 

Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 Is marked other this any Injury or other traumatic event, the once. Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Fletcher Wilkinson Kathleen Houghton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty W. Renn/Self 16 Norman Allen Street, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Evangelical
Lutheran Cemetery 20a. Method of Disposition 20c. Location - City or Town, State February 1 M Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26, 2007 Perryman, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee isman 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acouco C **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 menths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□ No 24a. Was an director, page 2 autopsy performed? (es 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2016 ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 6 Cother (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Joseph .

32. Registrar's Signature

M.D.

31. Date filed (Month, Day, Year)

2007

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AND STO 231 ANNAPOLIS, MD. 21401

			For State of Maryland / Dep	artment of Health and N artificate of Death		2007 07006			
7	1.5		Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death						
	Physicia /Medic		Month Day Year						
n.	Examin		Tebruary 20, 2007 12.55						
		3 11	Northampton Manor Nursing Home  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Frederick  If Under 1 Year   If Under 24 Hrs.	O Date of Birth	Frederick			
	Funeral Director	31	214-36-0274	Months Days Hours Min.	8. Date of Birth (Month, Day) Feb. 4,	, Year) Country)			
	70		Usual Residence of Decedent		Teb. 4,	1937  Maryland			
	arylar show d at	Funeral Director	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1X\\Yes 2 □ No			
	the M		Maryland Frederick Frederick  10e. Street and Number	10f. Zip Code		log. Citizen of What Country?			
	3a or		200 East Sixteenth Street	21701					
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show int, the Medical Examiner must be notified at			Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,			
ò	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, etc.  Specify:			
Š	hours tural",	ed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	edent's Usual Occupation		White			
2	in 72 n "na Nedic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/Industry			
7	d with giene er tha			driver and labore	er	Excavating Company			
3	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I	Maiden Surname)			
7	2 should be filed within n and Mental Hygiene. Is marked other than raumatic event, the Me	្វ	Wade Olin Rice  19a. Informant's Name/Relationship (Type. Print)  19b. Mail	Margie El					
2	and 2 sl salth an n 27 is r er traur			ing Address (Street and Number or Run					
ນົ	es 1 and 2 of Health fitem 27 I rother tra		20a. Method of Disposition 20b. Place of Disposition		Date	1orida 32129 20c. Location - City or Town, State			
	Pages nent of int: If its iry or o		IMBunal 2 Ucremation 3 Hemoval from State	e <sup>matory</sup> or other place)   2/23/ 1 Methodist Cem.		efferson, Maryland			
Ū	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.					Basford Funeral Home			
۵_	207 2 2			06 East Church Str					
	15		23a. Part. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arr	est, Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	y metastati to	bene a	nd lung over 2 years			
	Examiner					,			
0	n +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
8	executed n and ial-transit	Examiner	that initiated events						
Ç Q	be excian a	Ē	Due to (or as a consequence of):						
00/00	ficate be executed physician and s the burial-transit	edical	d						
ממא	The law requires that the death certificate be the has been signed by the attending physicia age 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery			
0	death e atte	sicia	in the past 12 months?  1 □ Yes 2 □ No  1 □ Yes 2 □ No	□Ectopic pregnancy □ Other (specify)		Month Day Year			
ר כ	at the	Completed by Physician/M	9 Li Onknown						
ń	signer bed		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown			
COLUS,	v requ		Justinia Maria						
ו כ	he lav e has	dmo			24a. Was a autops perfori	prior to completion of cause of			
g	an: T tificat tor, pe	Certification: To Be Co	25. Was case referred to medical	26. Place of Deatl	1 Yes	2XNo 1 ☐ Yes 2 ☐ No			
>	hysici nis cer direc		examiner? 1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:		ence 6 ☐Other (Specify)			
5 4	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 1njury			ow injury occurred			
VISIO	ttendi Jeath.		2 Accident investigation	M 1 Yes 2 No					
2	after of Direction by		4 Homicide determined determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours a To the Funeral I		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the c	ause(s) and manner as stated.			
	he Ho in 24 I he Fu pletel	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or i and manner stated	nvestigation, in my opinion, death occur	red at the time, d	late and place, and due to the cause(s)			
	Mith With Control	Σ	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)			
			1.000	D37178	F	February 20, 2007			
	5		30. Name and address of person who completed cause of death (Item 23a) (Type		37. 3	1 01717 1000			
	Sta	te	J. Christopher Fleming, MD, 610 Ninth 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Street, Brunswick	k, Maryl	and 21716-1828			
	Registr		31. Date filed (Month, Day, Year)  MAR 1 2007						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 06360 Certificate of Death Reg. No!--1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 02 Month **Physician** 2007 SHEILA RILEY 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours England Director 80 Jul 5, 1926 214-32-3588 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Nature. 10a. State 10c. City, Town or Location 10d. Inside City Limits Y⊟Yes 2 No MD Allegany Cresaptown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14612 Brant Road SW 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married X Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo þ Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesladv Casual Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Line Edith Louise (Parslo) Line မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 William Riley husband 14612 Brant Road, SW Cresaptown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2007 Sunset Memorial Park MD Cumberland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Ocardia **Physician** day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-tran resulting in death) Last Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal teilur 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Vikramadit

N 36766

Cumberland, Maryland 21502

			1- State of Maryland / Department State of Maryland / Department Certification	nt of Health and Mental Hy te of Death	ygiene 007 06361							
			Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death							
	Physici /Medic		EVIN SIERRA SIMMS	Month 62	17 2007 13:05 P M							
	Examin			, Town, or Location of Death	4c. County of Death							
				CKVILLE, MARYLANI								
	Funeral		Months		9. Birthplace (State or Foreign Country)							
	Director		Vone 1 M 2AF Yrs. World William Residence of Decedent	1 45 02-1	7-2007 MARYLAND							
	/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
	Mar.	żo	MD MONTGOMERY POOLESVILL	E, MARYLAND	1 Pes 2 No							
	or 28.	Director	10e. Street and Number 10f. Zi	p Code	10g. Citizen of What Country?							
	23a		17607 KOHLHOSS ROAD	20837	USA							
	er de	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?	edent of Hispanic Origin? (Specify Yes or N ecify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.							
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 3 Widowed 4 Divorced Year or Dates:	2 No Specify:	Specify: BLACK							
5-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show tha Madical Examinat must be notified at	ted	15. Decedent's Education 16a. Decedent's Usu	ual Occupation	16b. Kind of Business/fndustry							
215	P. "n Ned	Completed	Flementary/Secondary (0-12) College (1-4or 5+)									
2	filed will Hygien other th	S	D D IN	FANT								
Maryland	d all b	Be	17. Father's Name (First, Middle, Last)  ERNEST SIMMS	18. Mother's Name (First, Middle CHANTAL	BROWN							
7	should Ind Mening Ind Mening	10		s (Street and Number or Rural Route Num								
Ma	id 2 s Ith an 27 Is			^	LESVILLE, MARYLAND							
ā,	s 1 and f Health itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Na	ame of Date	20c. Location - City or Town, State							
Ë	Pages nent of int: If it		1 Burial 2 Octemation 3 Removal from State  4 Donation 5 Other (Specify)		HALL RIVER, NC							
Baltimore	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.			and Address of Facility	0.0							
<u>m</u>	89 = 9		Rout Berfell SHADY	GROVE ADVENTIST H	OSPITAL 9901 MEDICAL GITCLER							
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line.	de of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death							
	Physician		Immediate Cause (Final disease or condition resulting in death)  A Preterm delivery		3.133 4.13 534							
	/Medical Examiner		Preterm promoters previously contained membranes 1-2 de									
		ē		Membranes 3								
	d d anslt	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	cate be executed oblysician and the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):	Due to (or as a consequence of):								
8760,	ate be hysici the bu	dicai	d		47 444 444							
9	certific nding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy									
Box	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic p		23d. Date of delivery  Month Day Year							
o.	the day	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown									
Ρ.	requires that the een signed by th nould be detache	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?							
rds	w requires that been signed b should be det	ed b		1	Yes 2 No 3 Probably 4 Unknown							
of Vital Records,	> Q to	plet		24a. Wa	24b. Were autopsy findings available opsy							
Ä	The ate h page	mo			formed? death? 2 No 1 □ Yes 2 □ No							
/ita	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only								
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 XNo Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ D	the second secon								
OU (	fter	ion	a valual S I vicing	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	e how injury occurred							
Division	Attending r death. ector: After by the fune	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	rv. office 28f. Location	(Street and Number or Rural Route Number,							
Ö	after after I Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)							
	pspits hours unera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred									
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigatio and manner stated.									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	200. 01974101	c. License number	29d. Date signed (Month, Day, Year)							
			700 0 1 1 1 1	DD55699	2/17/2007							
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  15005 Shady Grove Rd, #130, Rockville	, MD 20850								
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, MD 10830								
	Regist		MAR 0 1 2007 Janes 15 April 1									

			1- Star State Amend #1 Per Phy				alth and Me	ntal Hygie Reg.	ne 0 0 7	06362
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ray bark	Barbara	Marie	Small		Date of Death Month FChman	Day Year Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street a	id number)		4b. City, Town, or Lo			4c. County of Deat	h
			Ellicott City Health			Ellicot			Howard	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. 66	last birthday) Yrs.		If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye 05-01-19		hplace (State or Foreign untry) hington, DC
	pur *		Usual Residence of Decedent  10a, State 10b, County	10c Ci	ty, Town or Lo	ocation				10d Jacida Ois Livis
	lanyik sho	ក	Maryland Howard		licott					10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmat be rollited at	Funeral Directo	10e. Street and Number	EI	TICOLL	10f. Zip Code		100	Citizen of What Co	
	with Ba or		3000 North Ridge Roa	.1				log.		unity :
	Jeath The 23	era	11. Marital Status 12. Was	Decedent Ever in U	I.S. 13.	21043 Was Decedent of Hisp		fv Yes or No-	U.S.A.	ncan Indian
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2 Married 1 If You	ed Forces? Yes 2 X No es, Give r or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1☐ Yes 2ሺ No	Mexican, Puerto Rio Specify:	can, etc.)	Black, White, etc.  Specify: White	
5	2 ho	Completed	15. Decedent's Education	-4d)	16a. Dece	dent's Usual Occupation	on	166	. Kind of Business/	Industry
<u>'</u>	thin 7	pie	(Specify only highest grade composition of the comp	ege (1-4or 5+)	life.	kind of work done dur DO NOT use retired)	ring most of working			
V	er th	Ö	12		UNK	NOWN		U	NKNIWN	
2	al Hy	Be (	17. Father's Name (First, Middle, Last)			18	8. Mother's Name (F			_
2	Meni Meni arke	ပ္	William Frank Small				The second secon		ina Feigl	
ğ	and ls m		19a. Informant's Name/Relationship (Type, Prin	•	1	ng Address (Street and				
2 2	and ealth m 27 her t		Sandra Barnhardt - Si		7552	Greenknol				
5	ges 1 f of H ff Ite		20a. Method of Disposition 1 X Burial 2-Cremation 3 ☐Removal	from State	Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date	e 20c	. Location - City or	Town, State
allimor	Pag tmen tant: jury		`4 □Donation 5 □ Other (Specify)		rt Lind	coln Cemeter	y 02/16/	2007 Br	entwood,	Mary land
0	permit Depar Impor any In		21. Signature of Funeral Service Licensee	lass	100	2. Name and Address of asch's Fund	P. Seal Corner	. P.A.		imore Ave. le, MD 20781
			23a. Part1. Enter the disease, or complication- shock, or heart failure. List only one cau	that caused the deat						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease Condition a	Me tan		Cholan	SioCarc	inoma		Onset and Death
	Examiner				,					
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Ś	a exe an ar rial-t		resulting in death) Last	ue to (or as a consec	luence of):					
00/00	ficate be executed physician and is the burial-transit	edicai	d							
			IF FEMALE:						13	
C. DOX	The law requires that the death certifule has been signed by the ettending hage 2 should be detached for use as	hysician/M	23b. Was decedent pregnant 1 23c. If ye in the past 12 months?	s, outcome of pregna Live birth 2 □ Feta Pregnant at time of c Unknown	ıl déath 3[	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year
ecords, P.	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contribution	to death but not res	ulting in the u	nderlying cause given i	in Part I.		co use contribute to	the cause of death?
5	w red beer	iete						24a. Was an	24h Were aut	opsy findings available
		Completed						autopsy performed	? prior to c death?	ompletion of cause of
VIE	siclar certif	Be	25. Was case referred to medical examiner?  Hospital:			Cther	6. Place of Death (C	-1		
5	Phys rthis ral di	. To	1 163 2 110	1 ☐ Inpatient 2 ☐ Date of Injury	ER/Outpatier 28b. Time o	IL SEL DOA		5 Residence  d. Describe how in	6 Other (Spec	ify)
	ding h. After fune	fi	1 Natural 5 Pending	(Month, Day Year)	Injury	Work?	s 2 □ No	. Describe How II	ijury occurred	
VISION	deati deati ctor: y the	ertification;	3 Suicide 6 Could not be	Place of Injury - At h	ome farm str			Location (Street	and Number or Ru	ra I Pouto Number
2	rs after al Dire	Certii	4 Homicide determined 209.	building, etc. (Special	ý)	ooi, ladory, onlos		City or Town, St	ate)	ai noute Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physicien: (Check only one) Medicel Exeminer: On and	o the best of my kno the basis of examina manner stated.	wledge, deat ation and/or in	n occurred at the time, vestigation, in my opini	date and place, and ion, death occurred	due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License n	umber	29d.	Date signed (Month	, Day, Year)
	82		41	en		1)3	30041	Fe	bruges 1	3 200/
	De		30. Name and address of person who completed Rawa Cabapas 31. Date filed (Month, Day, Year)	cause of death (Iter	n 23a) (Type,	Back for	neck	Road	Balkm	ne Mayland
	Sta Registr		31. Date filed (Month, Day, Year) FEB 16 2007 Face	32. Registrar's Signa	ature	•				4221
			A / Market	N. Popular	-					

Robert Craig Speicher State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day February 11, 2007 Medical Examiner Robert Craig Speicher 1230 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health System Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 213-76-3719 49 June 20,1957 Country) Maryland 1 X M 2 F Usual Residence of Decedent 10b. County E 10a. State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No 23a or 28a-f shov Grantsville MD Garrett filed within 72 hours after death with the Maryland rector 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö 21536 137 Main St. USA Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Race - American Indian, Black or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc 1 X Never Married 2 Yes 2 X No Divorced White Widowed 4 If Yes, Give Year 1 Yes 2 X No specify: Specify: than "natural" ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) & Reporter Completed Elementary/Secondary (0-12) College (1-4 or 5+) t of Health and Mental Hygiene.

If item 27 is marked other than "
ther traumatic event, the Medical 21215-0036 Freelance Photographer 5 +Newspaper 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Karolyn Kay Beachy Robert H. Speicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Q N P.O. Box 6, Grantsville, MD 21536 Robert H. Speicher/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery Feb. 13, 2007 Grantsville, MD Donation 5 Other Specify 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 21536 lumau 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Hypertensive heart disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED attending physician or use as the burial AMELYSE, PII, 27, perME, g865, 3/16/07 TT P.O. Box 68760 IF FEMALE 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? has been signed by the attendi 2 should be detached for use Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of liver Completed Records, 24a. Was an 24b. Were autopsy findings available After this certificate has been autopsy prior to completion of cause of performed' death? page ✓ Yes 2 1 🗸 Yes the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 ✓ Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred 28a. Date of Injury Certification: (Month, Day, Year X Natural ithin 24 hours arter control to the Funeral Director: 1 Division 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the one) and manner stated 29b\_Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) February 12, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			For State Ragistrar	State of	Marylan				ealth a	and M	lental Hyg	jiene	97	06364
	Physicia	an	Decedent's Name (First, Middle, I Melchora	Last) M.	Sal	laysay					2. Date of Dea Month February		Year	3. Time of Death 11:10 P M
	/Medic Examin		4a. Facility Name (If not institution, G Ft. Washington Hos	give street and nun					Location o	of Death		4c. Coun	ty of Death ce Geor	
	Funeral Director		N/A	Sex 1☐ M 2☐F	7. Age ( <i>In yr</i> s. 47	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth OI/O6/I9	60° ar)	9. Birthi Ph 1.	place (State or Foreign ntry) ippines
	ryland		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo								10d. Inside City Limits
	the Ma	recto	Maryland Prince G	eorge's	ŀ	t. Wash	ington 10f. Zip				1	l 0g. Citizen o	What Cou	1 ☐ Yes 🌪 No ntry?
	ath with s 23a or nust be	ral Di	406 Kerby Parkway			2 10		207		:-0./0			ppines	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1√√√√√√√√ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Fo	dent Ever in U rces? 25 No e ates:		Was Deced f Yes, sped I ☐ Yes		Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)  14. Race - Ame Black, Whit Specify: Fil		ace - Ameriack, White,	etc
Maryland 21215-0036		omplete	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		-4or 5+)		dent's Usua kind of wo DO NOT u ekeepe	rk done d se retired	ation during most i)	t of work	ing	16b. Kind of Self -		
/land;	uld be filed Mental Hyg Irked othe Itlc event,	To Be C	17. Father's Name (First, Middle, La Protacio	Salaysay					_	r's Name istin	a (First, Middle, a	Maiden Suma Vicente	ıme)	
Mary	od 2 sho lith and ! 27 is ma r trauma		19a. Informant's Name/Relationship Marites Vann / Si				-				al Route Number ngton, Ma		n, State, Zip 20744	
Baltimore,	bages 1 are of Healent: If Item		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spe			Place of Dispo cemetery, crem				eb.	Date 19,2007	20c. Location General hilippi	Nativio	own, State lad,
Balti	permit. I Departm Importal any injur	*4 Donation 5 Other (Specify)  Mataas Na Kahoy Cemetery  1 Eg. 19, 2  21. Signatur of Funeral Service Knownee  22. Name and Address of Facility George  6160 Oxon Hill Road Oxon H									rge P. Ka	las Fune	eral Ho	
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8760,	cate be executed bhysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (	or as a conseq	quence of):								
.O. Box 68	death certifi e attending I ad for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	Ectopic pi Other (sp				\		ate of deliver	ery Day Year
Ф	w requires that the been signed by th should be detache	by	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did to		ntribute to t	he cause of death?
Vital Records,	The law ate has b page 2 s	Completed					· .				24a. Was a autops perform	sy med/?	prior to co death?	opsy findings available impletion of cause of
	Physician: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1	Hospital:	npatient 2	ER/Outpatien	nt 3□ DC	Othe	200		n <i>(Check only or</i> me 5 ☐ Resid		ther (Specia	6.1
ion of	ding h. After fune	H- 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date (Mont	of Injury th, Day Year)	28b. Time of Injury	-	8c. Injury Work	/ at		28d. Describe h			y)
Division	or Attencation death Director:	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At h ng, etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factor	, office			28f. Location (S City or Tow		ber or Aura	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	edical C		Physician: To the caminer: On the band man										
1	To the within 2 To the complet	Me	29b. Signature and title of certifier	neu		nd	290	. License	number	76	32	9d. Date sign	ed (Month.	Day, Year)
2	6		30. Name and address of person with Tames Mitch	-				Road			gton, Mar	vland	20744	* T
	Sta Registr		31. Date filed (Month, Day, Year) FEB 15 2007	32. R	egistrar's Signa	ature .					<u></u>	,		

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

		•	For State Registrar	State of Ma	_	partment of F ertificate of			enez () () []	06365			
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	3. Time of Death			
	/Medic	al .	WILLARD H. ST			4h Cihi Taum	r Location of Death	FEBRUAR	Y 12 20 4c. County of De				
	Examin	er	4a. Facility Name (If not institution, grant TALBOT HOSPIC)				ASTON		,	LBOT			
	Funeral				e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)			
	Director		219-34-2807	14 M 2□ F	75 Yrs	Months Days	Hours Min.	APRIL 3	1931 M	ARYLAND			
	pur M	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location	ocation 10d. Inside City Limits						
	Maryla f eho	5	MD TAL	OT.		EASTON				1 XYes 2 □ No			
	the the 28a-	Director	10e. Street and Number	501		10f, Zip Code		10	g. Citizen of What 0	Country?			
	daath with the Maryland ma 23a or 28a-f ehow rinust be batified at	io ie	640 MECKLENBURG	AVE., APT	#123		21601		1	JSA			
õ	in 72 hours aftar daath with the Manylan "natural" or Itema 23e or 28e-f show builgal Examalar must be builfied at	y Funeral	11, Marital Status  1 Never Married 2 Married	12. Was Decedent 8 Armed Forces? 1  Yes 2 If Yes, Give		3. Was Decedent of H If Yes, specify Cuba  1 Yes X No		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - An Black, Wh Specify: Ln				
3-003p	hours tural',	ed by	3  Widowed 4 Divorced  15. Decedent's	Year or Dates:	16a De	cedent's Usual Occup	pation	1	6b. Kind of Busines				
<u>.</u>	in 72 n "nal	Completed	(Specify only highest g	rade completed)	(G	ive kind of work done  o. DO NOT use retired	during most of world)	king	STATE HI				
7 7	d within giana. rr then "	mo:	Elementary/Secondary (0-12)	College (1-4or 5		Y EQUIPMEN	NT OPERAT	OR	ADMINIST				
and	be filac tal Hyg d othe	Bec	17. Father's Name (First, Middle, Las	(t)			18. Mother's Nam	ne (First, Middle, M	laiden Sumame)				
Z	ould b	2	WILLIAM STERLING				L	LA MANSF					
Mar	d 2 sho		19a. Informant's Name/Relationship	• • •		ailing Address (Street							
a) a	s 1 and f Haalth Item 27 other t		LEONA F. STERLI	NG/WIFE		O MECKLENI sposition (Name of	BURG AVE.		Oc. Location - City of				
Baltimor	80= 5		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	rify)	WOODLAW	N MEMORIA	L PARK 2/	16/2007	EASTON, 1	MARYLAND			
ga	parmit. Pag Dapartmant Important; eny injury o	() ()	21. Signature of Funeral Service Lic	MERCER	20~ 0	22. Name and Addre ELLOWS, HI	RISON ST	EASTON, 1	ID 21601	HOME PA			
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin	the death. Do not one.  two care a consequence of):	enter the mode of dyir		or respiratory arre	st,	Approximate Interval Between Onset and Death			
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rds, P	quiras that n signad b uld ba data		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause give	ven in Part I.			to the cause of death?  Probably 4 2 Inknown			
Hecords,	Physicien: Tha law requir this cartificeta has baan si al diractor, paga 2 should I	Completed by	Type II &	Dealet	277	ellitu	2	24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of			
VIta	artifice ctor.	Be C	25. Was case referred to medical examiner?					ith (Check only one					
	Attending Physicien: ir daath. ector: Attar this cartific by the funeral director.	ို	1 Yes 2 No	Hospital: 1 ☐ Inpatie		IIIII 3 DOA			nce 6 COther (Sp	ecity) HOSPICE			
Ē	ttending P daath. :tor: Aftar i tha funara	ou:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Year) Injui	y Wo		28d. Describe ho	w injury occurred				
<u>s</u>	daath. daath. ctor: A y tha fu	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 29a Blace of Ini	uny - At home form	M 1 Street, 1actory, office	]Yes 2□No	281 Location (Str	eet and Number or	Rural Route Number,			
Division of	l or Attendation after daati	Certification:	4 Homicide determine	building, et	c. (Specify)	street, ractory, omoc		City or Town,	State)	Tural Tidate (Valleon,			
	To the Hospital or At within 24 hours after of To the Funaral Direct complataly fillad in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination and/o	eath occurred at the till r investigation, in my o	me, date and place, opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)			
	ro the	Me	29b. Signature and title of certifier	> / A	1	29c. Licens	se number	29	d. Date signed (Mo	nth, Day, Year)			
	,- > p= 0		Yarala.	delmil	(11)	200	5360	2	2/13/0	7			
	1 -		30. Name and address of person wh	o completed cause of	leath (Item 23a) (Ty	pe, Print)		-   0	1 -10				
_	-6-		Carolyn Helmly,	MD 508 Id	llewild A	e Easton	, Marylan	d 21601					
	Sta Registr		31. Date liled (Month, Day, Year) <b>FEB 1 4</b> 200	2.45	ar's Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HELEN ELIZABETH SHORTALL 0505 February 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot Hospital Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 22, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 T F 90 MARYLAND Director 217-82-3739 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 X Yes 2 No Director **EASTON** MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 21601 #8 ST. JAMES COURT USA Funeral Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: Specify: þ 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) O HOMEMAKER OWN HOME 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES CARROLL BARCUS SARAH MATILDA SLAUGHTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL C. SHORTALL/SON 200 GREENVILLE FARM LANE, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State ST. PETER'S CEMETERY 2/16/2007 QUEENSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 SCHOL MERCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ena **Physician** ear /Medical Due to (or as a consequence of): Examiner VKa squentially set corollors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the b IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy pertorme death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division Injury 1 Natural 2 Accident 5 | Pendina spital or Attendi nours after death. neral Director: A filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

60-

Daniel 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

MD

tast

12,2001

				1 - State Registrar	e of Maryland / D (	epartment of I Ce <i>rtificate of</i>		fental Hygie Reg.	211111	06367
		Physic		Decedent's Name (First, Middle, Last)     THOMAS WILLIE SAWY	er Er			2. Date of Death Month 02	Day Year 10 2007	3. Time of Death
		/Medi Examir		4a. Facility Name (If not institution, give street and	i number)	4b. City, Town, o	or Location of Death	02	10 2007 4c. County of Dea	5:15 A <sup>M</sup>
		LAGIIII		HARFORD MEMORIAL HOSP					HARFO	
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign ountry)
		Director		409–40–1495 TAM 2 Usual Residence of Decedent	76 Y	15.		OCT 13,	1930 TI	ENNESSEE
		ehow	١.	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
		oth with the Maryla 23a or 28a-1 ehoves	ctor	MARYLAND HARFORD		HAVRE DE (	GRACE			1 X Yes 2 ☐ No
3/1		with th	Die	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
6		ss 23a	eral	142 N. WASHINGTON STRI	Decedent Ever in U.S.	12 Was Doordont of h	21078	anifu Van as Na	USA	ninga ladias
351	36	72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show scal Examiner invat be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☑ Y	d Forces? es 2 No , Give or Dates: 1950-71	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No		ecity Yes or No- Rican, etc.)	14. Race - Ami Black, Whi Specify: BI	te, etc.
0	Maryland 21215-0036	72 hours natural'	ted	15. Decedent's Education	16a. E	Decedent's Usual Occup	pation	. 16b	o. Kind of Business	/Industry
	215	C	Completed		ge (1-4or 5+)	Give kind of work done life. DO NOT use retire	during most of work ed)			
	121	be filed withintal Hygiene. Ind other therewent, the Mevent,		12		WELDER			US ARMY	
	and	d be find H	Be	17. Father's Name (First, Middle, Last) THOMAS SAWYER				e (First, Middle, Maio	den Sumame)	
	Z	s 1 and 2 should be to the file of the fil	၉	19a. Informant's Name/Relationship (Type, Print)	19b. l	Mailing Address (Street	KATIE F		ity or Town State	Zin Code)
1		nd 2 sallth ar		ELIZABETH SAWYER / WIE						E, MD 21078
0	Je,	ss 1 and 2 of Health a item 27 la other trai		20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other pla	,		. Location - City or	
101	Ë	Pages ment of ant: If it ury or o		1 XBurial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State	N FOREST VE	- 1	/07 OW	INGS MIL	LS, MARYLAND
2/1	Baltimore,	permit. Pages Department of I Important: If its any injury or of anges.		21. Signature of Funeral Service Licensee	Coloman	22. Name and Addre LISA SC 552 LFW	ess of Facility OTT FUNER VIS STREET	AL HOME,	P.A. E.GRACE	MD 21078
				23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do no	t enter the mode of dyir	ng, such as cardiac o	or respiratory arrest,	is civicity	Approximate Interval Between
	ż	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ARDIAC A					Onset and Death
		Examiner		Re	SPIRA TORY	non	+			
VD		D #	Examiner	cause. Enter Underlying	to (or as a consequence of	):				
		ecute and I-trans	xam	that initiated events c. / /	VEUMON 4 to (or as a consequence of	).				<del></del>
	68760,	tificate be executed ig physician and as the burial-transit	edical E	a EN	terococcu:		TRACT I	rectio	N	
	-	ntifica ng ph a as th		IF FEMALE:						
SHI	P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy ve birth 2 ☐ Fetal death regnant at time of death nknown	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of de Month	ivery Day Year
homa		res that thigh of igned by be detact	by Ph	Part II. Other significant conditions contributing		he underlying cause giv	ren in Part I.	23e. Did tobacc	co use contribute (	the cause of death?
1	rds	equire en sig ould b	ed b	CIRRHOSIS OF L				1 ☐ Yes	2 No 3 ₽	obably 4 Unknown
3	Division of Vital Records,	sician: The law re certificate has be rector, page 2 sho	Completed	My elody splastic	. SYNDRO,	ME		24a. Was an autopsy performed	?   death?	utopsy findings available completion of cause of
2	ital	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death	1 Yes 2	NO TOTOS	2□ No
3	<u>&gt;</u>	hysic his ce I dire	P P		npatient 2☐ ER/Outp	atient 3 DOA Oth		me 5 Residence	6 Other (Spe	city)
5	on c	Attending Physician: r death. sctor: After this certifics by the funeral director, p	Certification:	1 S Natural 5 ☐ Pending	ate of Injury Month, Day Year) 28b. Tin	ury Wor	yat rk? Yes 2 □ No	28d. Describe how in	njury occurred	
	/isi	Attend r death ector: /	flca	2 Could not be	ace of Injury - At home, farmuilding, etc. (Specify)			28f. Location (Street	and Number or Ru	ural Route Number
	Ö	s after Ni Dire	Certi	4  Homicide determined b	uilding, etc. (Specify)			City or Town, St	tate)	
		To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Physician: To (Check only one) 1 Medical Examiner: On the and of	the best of my knowledge, one basis of examination and/	death occurred at the tir or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
		To the within 2 To the complet	Ž	29b. Signature and title of certifier.	2 0 6	29c. Licens	se number	29d. I	Date signed (Monta	h, Day, Year)
				Vu. Woll	n	1)6	5072	2	15/07	•
		1		30. Name and address of person who completed of	cause of death (Item 23a) (T	ype, Print)	. //	1 /	7 1	1
		1		HPURUA DESAI, 31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	UNION H	ve HA	ure de 6	RACE, 1	10.21078
	*	Sta Registr		FED 1 6 2007	Messur &	Sperter				

			1 - For State Registrar	State of Ma	aryland / Depa	artment of rtificate of			giene 007	06368		
	Dhuaiai		1. Decedent's Name (First, Middle, Las		1 1 0			2. Date of Dea	ath Day Year	3. Time of Death		
	Physici /Medic		Wells to	rd -	tever	و و	· -	Freb	10 2007	2300 M		
	Examin		4a. Facility Name (If not institution, give	1 (	600	4b. City, Town,	or Location of Deat	eath 4c. County of Death				
				,	sev	If Under 1 Yea	Ir If Under 24 Hrs.	To Date of Birth	17 14			
п	Funeral Director			ox 7. Age ox 2 F	a (In yrs. last birthday) 69 Yrs.	Months Day		8. Date of Birth (Month, Day Jan 22,	n 9. Birthr (1938 Wash	place (State or Foreign ofry) ington DC		
			Usual Residence of Decedent			1		Juli 22,	, 1230 Masii	Ingcon bo		
	yland		10a. State 10b. County	3 - 1	10c. City, Town or Lo				1	0d. Inside City Limits		
	Mar e-f st	iç	MD Anne Arur	idei	Crownsvi	TTE				1 □Yes 2 No		
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number	•		10f. Zip Code			10g. Citizen of What Cour	ntry?		
	ath w 238	ral	1164 St. Stepher				.032		USA			
	er de	nue	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent <i>o</i> f If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,			
36	rs aft	γF	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1	7/20/57-	1 ☐ Yes 2 🖾 N	o Specify:		Specify: W	hite		
21215-0036	2 hou	ed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occi	upation		16b. Kind of Business/In	dustry		
215	nin 72	ple	(Specify only highest gra	de completed) College (1-4or 5	life.	kind of work don DO NOT use retir	e during most of wor red)	king				
21,	giene giene er the	Completed	Elementary/Secondary (0-12)		Owner	/Operato	r		Marine Rep	air		
pu	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)	. d. a. m. d	C+				Maiden Surname)			
yla	should the mind Meni	မ		ijamin	Steven		Elizabet		Ward			
Maryland	permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be rollined at once.		19a. Informant's Name/Relationship (7 Doris L. Stevens	Гурө, Print) Wife	19b. Mailii 1164	ng Address <i>(Stree</i> St. Step	et and Number or Ru hen's Chu	ral Route Numbe rch Road	r, City or Town, State, Zip Crownsvill	Code) e MD 21032		
	1 and Healt am 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - City or To			
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Metro Cr	natory`or other pi ematory		13,07 B	altimore,MD	,		
Ħ	artme artme ortan injur		21. Signature of Euneral Service Licen			2. Name and Add			851 Annapo	lis RD		
B	permit. Departr Imports eny inju		Date A	WIII	Н	ardesty	Funeral H	ome P.A.	Gambrills.			
			23a. Part1. Enter the dis lase, or comp shock, or heart failure. List only	olications that caused	the death. Do not ent	er the mode of dy	ying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Acr	to OA	rdiac	Avr	Ly-H in	MIA	Onset and Death		
1	/Medical		resulting in death)	Due to for as a	a consequence of):	7.	1 /	15				
ľ	Examiner		Sequentially list conditions.	b. Styl	eriosel	erotic	HeA	+ 1)1	SEABRE			
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	and I-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or as:	a consequence of):							
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68760	phys phys s the		100	d								
Box (	he death certifics the attending ph ched for use as I	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	arv		
ă	Jeath atter	clar	in the past 12 months?	1 □Live birth 4 □ Pregnant at		]Ectopic pregnan ] Other (specify)	су		Month	Day Year		
P.O.	res that the de signed by the a l be detached f	Physiclan/Med	9 Unknown	9□ Unknown								
	is that	by P	Part II. Other significant conditions co	ontributing to death bu	it not resulting in the u	nderlying cause g	given in Part I.	23e. Did to	bacco use contribute to th	ne cause of death?		
Records,	w require been sig should b	edi						1 🗆 Y	es 2 No 3 Prob	ably 4 Dúnknown		
000	aw re	plet						24a. Was a		psy findings available inpletion of cause of		
Ä	sician: The law s certificate has b lrector, page 2 s	Completed				·		perfóri	med? death?	2□ No		
Vital	Physician: this certificaral director, p	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or				
of V	hysic his ce I dire	P	1 ⊠Yes 2 □ No	Hospital: 1   Inpatie		IL SLI DOA		ome 5 🗆 Reside	ence 6 Other (Specify	<i>y</i> )		
ū	ing P	ü.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	W		28d. Describe h	ow injury occurred			
Sio	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		Int. At home form at		]Yes 2∏No	20f Logotion (C	Street and Number of Burn	I Davida Number		
Division	l or Al after of Dirac	Certification:	4 Homicide determined	building, etc	iry - At home, farm, str :. (Specify)	еет, тастогу, опісе	9	City or Town	treet and Number or Rura n, State)	I Houte Number,		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funarel Director: After this certificate he completely filled in by the tuneral director, page	al C							ause(s) and manner as st			
	ha Ho in 24 i ha Fu pletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or in ted.	vestigation, in my	opinion, death occu	rred at the time, d	date and place, and due to	the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier	10	Deputy		nse number		29d. Date signed (Month.	Day, Year)		
			Miller	PA	Sul a	D	00039		2/10/			
	(X)		30. Name and address of person who			Print)	06054 Amer	, n	0 -6			
	.)		William Pu	Jenes	W D	æ 95	Monter	CH	21035	7		
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Hegistra	r's Signature	med !						

			1 - State State Registrar	of Maryland / [		rtment of He tificate of D			jiene eg. No.	07	06369
	Physici	an	Decedent's Name (First, Middle, Last)  John Francis	Stitely	<u> </u>	r.		2. Date of Dea Month Februar	th	2007	3. Time of Death 6:55 A M
	/Medio Examir		4a. Facility Name (If not institution, give street and no	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or	ocation of De			nty of Death	0.55 A M
			Kline Hospice House			Mount Ai	ry If Under 24 H	8. Date of Birth (Month, Day July 7,	Frederick		
	Funeral Director		5. Social Security Number 214-28-5931 6. Sex 1 M 2 F	7. Age (In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days	9. Birthp Cour Mary	place (State or Foreign ntry) land			
	yland Now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Towr	n or Loc	ation				1	10d. Inside City Limits
	Ba-fat	ctor	MD Frederick	Unior	n Br	idge					1 Yes 2 No
	with the same or 2	Funeral Director	10e. Street and Number 12419 Coppermine Rd.			10f. Zip Code 21791		1	0g. Citizen o	of What Cour	ntry?
	death	nera	11. Marital Status 12. Was Dec	cedent Ever in U.S.	13. W			(Specify Yes or No- erto Rican, etc.)	14. P	Race - Americ	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nature!", or Items 23s or 28s-f show says figury or other traumatic event, Ite Madical Examinar must be notified at ODGS.	ğ	1 Never Married 2 Married 1 Yes G  3 Widowed 4 Divorced Page 7	2 <b>/^</b> No ive			Specify:	erto Hican, etc.)		slack, White, c <i>ify:</i> Wh	etc. ite
Maryland 21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed		Decede (Give k	ent's Usual Occupat and of work done du O NOT use retired)	ion Iring most of v	vorking	16b. Kind of	Business/In	dustry
12	within ene. then	dmc	Elementary/Secondary (0-12) College	(1-4or 5+)		r/ securi			dairv/	'rubbe	r co.
م م	I Hygi other	Be Co	17. Father's Name (First, Middle, Last)					lame (First, Middle, I			
ylar	Menta Menta arked	10 E	Norman E. Stitely				Oley	Irene Bl	ack		
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)					Rural Route Number			
ē,	s 1 an f Heal Itam 2 other		Donnie K. Stitely - son 20a. Method of Disposition	20b. Place of	Dispos	ition (Name of atory or other place	ne ka.	, Union B		n - City or To	
<u>E</u>	Page ment o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		Cemetery	- 1	3/2007	Liber	tytowr	n. MD
Baltimore,	permit. Departimporti		21. Signature of Funeral Service Licensee			Name and Address 4 S. Main	of Facility	Hartzler Woodsboro	Funer	al Hon	
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do n							Approximate Interval Between
ı	Physician /Medical	4 5	tmmediate Cause (Final disease or condition resulting in death)	Strok	9						Onset and Death
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Division of	ng Phys fter this neral di		27. Manner of Death 28a. Date	of Injury 28b. T	·	28c. Injury a Work?		28d. Describe ho			facility
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<u>≥</u>	al or A after I Direct d in by	Certification;	determined 200. Flat	e of Injury - At home, far ling, etc. <i>(Specify)</i>	m, stree	et, ractory, office		28f. Location (Sti City or Town	eet and Nun , State)	n <i>ber</i> or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours atter death 'To the Funeral Directors After this certific completely filled in by the funeral director,	edical C	29a. Certifier Check only one) Certifying Physician: To the to and man	e best of my knowledge, pasis of examination and iner stated.	, death (	occurred at the time estigation, in my opin	, date and plantion, death oc	ce, and due to the ca curred at the time, da	use(s) and r ite and place	manner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\		29c. License	number	29	d. Date sign	ned (Month, I	Day, Year)
	WJL		· Herely	1)		D3105	8		Feb.	12, 2	2007
	5		30. Name and address of person who completed cau Gene (Ashe MD 10200	se of death (Item 23a) (1 Coppermine		,	ro MD	21798			
	Sta	te	31. Date filed (Month, Day, Year) 32. I	Registrar's Signature			, , no	21/30			
	Registr	ar	FEB 1 5 2007	Glasur H.		law.					

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 22, 2007 **Physician** Charles Irvin Sayers 4:42 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aberdeen 601 Cornell Street Apt. 218 Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6 1/2/4 / Pag 3437 9. Birthplace (State or Foreign **Funeral** 1**ĕ**M 2□ F Months Days Hours 216-30-8964 71 Vrs Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at MD Harford Aberdeen Director 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Cornell St. Apt. 218 21001 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ont: If item 27 is marked other then "neturel", or Itel 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Thomas Sayers Stella Gertrude Bragg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Terry (Friend) 2006 Pulaski Highway, Havre de Grace, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
R. A. Ferris & Co. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department Importent: If any injury or 2/24/07 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) <sup>22, Name and Address of Facility</sup>
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medlcal as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods 3 Probably 4 □Unknown 1 | Yes 2 ₽ NO Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 24 No 1 Yes 25. Was case referred to dical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Bestdence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 🗌 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Mann Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 pertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, of death (Item 23a) (Type, Print) Marila 31. Date filed ( State 2007 Registrar

			For State Registrar	State of	Marylar		artmen rtificat			and M	lental Hyg	giene	)7	06371
	Discosial		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ith Day	Year	3. Time of Death
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j	Examir	er	4a. Fecility Name (If not institution, giv				4b. City,		Location of			4c. Coun	ty of Death	
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	Funeral Director			1 M 2 □ F	49	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 5,	/, Year)	Mary.	place (State or Foreign ntry)
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	nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo								10d. Inside City Limits
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10	ter de	un-	11. Marital Status  1 ☐ Never Married 2 ☒ Married	Armed Force	s?	i			n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	BI	ack, White,	etc.
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N	d 2 th a th a trail		Mary Rebecca Tyle	er (Wife)			-				) Cri	-		21817
re,	f Heal item 2 other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of ther place	a) 1		Date	20c. Location	- City or T	own, State
E	Page nent c int: if		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special		16	nyriæje			1	2/20	0/07	Crisfi	ed, M	ID .
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20028.		21. Signature Fin. IS mice Lice Robert H. Brad	Ishaw, Jr	1						eral Hon		817	
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9	tificat ng phy as th	8										77-11		
Вох	death certifica e attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pr	egnancy					ate of deliv	*
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J Of	ding Phy. h. After thi funeral	n.	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of	1 2	8c. Injury Work			28d. Describe h			,,
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Division	or Att	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At h etc. (Specia	ome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Number,
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	To the I within 2 To the I complete	M	29b. Signature and title of certifier				290	. License			2	9d. Date sign	ed (Month,	Day, Year)
			<b>(</b> V	V	+	9		$\mathcal{D}$	A87	098		2/21	1200	07
			30. Name and address of person who	completed cause of	of death (Iter	m 23a) (Type,	Print)							
			Vijay Karumbu	nathan, M	.D	201 H	all H	ighwa	ay -	Cris	field,	MD 218	317	
	Sta Registi		31. Date filed (Month, Day, Year)  FEB 2 0	2007	strar's Signa	aiure Ju								
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DHMH 17 Rev 1/2001

ORIGINAL

07-01134 William Travers

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		1- For State Registrar	e or ivial yland		cate of Dea		_	eg. No.	7 0007			
Physici Medical Exami		1. Decedent's Name (First, Middle,	Last) Land Travers	- Cm			2. Date of Dea Month February		3. Time of Death			
/		4a. Facility Name (if not institution,			4b. City	, Town, or Location of De		10, 2007 4c. County of Deati				
		University Hospital			Balt	impre						
Funeral Director		215-58-6173	5. Sex 7. Ag	e (In yrs. last b	oirthday) If Ur Yrs. Mon			5, 1951 Foreign	thplace (State or gn untiMaryland			
any		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location				10d, Inside City Limits			
* .	or	Maryland Dorche	ester		Cam	bridge			1 es 2 No			
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215-0036 be filed within 72 hours after death with the Maryland natal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	12	College (140)	5+)	Boat C	arpenter		Boat Maint	enance			
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imore, MD 2 Pages I and 2 shou ment of Health and I tant: If item 27 is n or other traumatic		Deborah Traver	s/Former Wi	fe	406 Crea	amery Lane,	Centrevi:	lle, MD 21	617			
Ore, es I an of Hea If iter		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from Str		e of Disposition (N latory or other plac		Date	20c. Location - City or	Town, State			
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		4 Donation 5 Other Spe 21 gnature of Funer Pervice Li		MidSh	noreCrema	ationCenter	2/12/200	Cambridg	e, MD			
Bal perm Depa Impo injur		Olled Toxers	Clustoran Januale   Curran-Bromwell Funeral Home P. 308 High St., Cambridge, MD 2161									
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Box 687  he death certific  the attending ped for use as the	Physician/	1 Yes 2 No 9 Unkno	4 4.		5 Other (Sp	ecify)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year RUED 0230 M 2 l٥ 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Voor 1 M 2 □ F Hours 220-24-7224 Director Sep 6 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md Anne Arundel "natural", or items 23a or 28a-f sh edical Examiner must be notified Annapolis Director 1 ☐ Yes XX No 1 and 2 should be filed within 72 hours after death with the health and Mental Hygiene. • m 27 is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 18 Steele Ave 21401 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

17 Yes 2 No 1950- Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: þ Specify. 3 Widowed 4 □ Divorced 1954 White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 Is marked other than " traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Artist EPA/Small Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W Truett Sr. Lillian Elizabeth Wyble ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 anu z ... rtment of Health ar Heidi Ferrell 171 Edenderry Ave. Daughter Centreville, MD 21617 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nurial 2 ☐ Cremation 3 ☐ Removal from State = 6 Department o Important; If any injury or Md Veteran Cemetery Feb 16 2007 Crownsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signation of Funeral Septime 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 /Medical **Examiner** 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Tes 2 No 3 Probably 4 Number page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy perform 27 1∐ Yes Physiclan; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Death 28b. Time of After ! 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

To the Hospital or At within 24 hours after d To the Funeral Directory completely filled in by

State Registrar

31. Date filed (Month, Day, Year)
FEB 1 3 2007

29b. Signature and title of certifier

Name and address of person



o completed cause of death (Item 23a) (Type Print)

Soul

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** February 12 2007 40 County of Death /Medical <u>Jeannette Heath Bachmann Wilson</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KICOMICO PENINSULA REGIONAL MEDICAL SQLISKIM If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Days Hours 90 Director 212-14-9342 -3-1917 Bivalve, Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 Canal Park Dr., Apt. 402 USA
14. Race - American Indian, 21804 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 12 d 2 should be filed w h and Mental Hygieu 7 is marked other th Secretary Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Luther J. Heath Mattie Messick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9911 Martin Ct., Berlin, Maryland 21811 <u> Carol Prager – daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2-13-07 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service License 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complic shock, or heart failure. List only or tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Abdominal Aontic anunysm disease or condition resulting in death) 2 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ၉ 2 ER/Outpatient 3 DOA I Director; After this of in by the funeral d 27. Manner of Death 12 Natural Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a

To the Funeral I 🖰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D05135

DHMH 17 Rev 1/2001

State Registrar MD 21804, Usha Natesan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

S. DIVISION ST, SAUSBURY,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 09Day 2007 8:13P WIMBUSH DEBORAH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06-06-1950 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 □XF WASHINGTON, DC 579-68-1840 56 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGE HYATTSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 U.S.A. 5605 31st AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by If Yes, Give Year or Dates: 3 TWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DŘÏVER PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUTH E. LYONS PURCELL R. CAMPBELL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 31st AVENUE HYATTSVILLE, MD 20782 MICHELLE CAMPBELL/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND NATIONAL 02-17-2007 LAUREL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, o shock, or heart failure. Light complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a I ⊈Yes 2 ₽ No 9 Unknown Part II. Other icolficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of filled in by the funeral 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Natural
2 ☐ Accident 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number re and title 29d. Date signed (Month, Day, Year) DYTGG DPINDER SINGH, MD who completed cause of death (tem 23a) Type, Print) ALC AL State

Registrar

FEB 16 200

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#29d.PenPhys.PGC2-23-07cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Charles Withgott 14 2007 3:35 A M February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12414 Stretton Lane Bowie Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec. 31 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) Months 1**∑**M 2□F Director 440-32-0195 74 1932 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 TYYes 2 □ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12414 Stretton Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. Armed Forces: 1 Types 2 No If Yes, Give Year or Dates: 1955-57 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer NASA other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental Hiant; If item 27 Is marked ott Be Charles B. Withgott ပ Velma Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coeta Faye Withgott / spouse 12414 Stretton Lane Bowie, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. Veterans Cemetery: 02/20/2007 Crownsville, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any ir Beall Funeral Home m 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complice shock, or heart failure. List on hins hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, car se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ABDOMINAL SARCOM A disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 ☐ Unknown þ det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Dunknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natura! 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a the Funeral I the Hospital 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2/15/2007 29b. Signature and title of certifier 29c. License number D54689 MD 30. Nam, and address of person who impleted cause of death (Item 23a) (Type, Print) Swite 14999 Health Center Dave OM, DUANG, MD 201 31. Date filed (Month, Day, Year) 32. Registrar's Signaty State 1 6 2007

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06377 State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month JOANNE WILLIAMS 02 2007 5:30P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🖾 F Vrs 577 -70-1341 55 MAY 19. WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Y☐Yes 2☐No PRINCE GEORGE LANDOVER 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 6813 WEST FOREST RD #101 20785 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER PRIVATE 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEVI BOONE SR. PATTIE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN WILLIAMS/DAUGHTER 6813 WEST FOREST RD #101 LANDOVER, MD 20785 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY | 02-16-2007 RIVERDALE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AORTIC DISSECTION Due to (or as a consequence of): Sequentially list conditions Due to or as a consequence of ce of): ath

**Physician** /Medical Examiner

> the burial-transit end

physicien

signed I

**Physician** 

/Medical

Examiner

10a. State

MD

Direct

Funerai

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Completed

Be

**Funeral** 

Director

23a or 28a-f ehow

the Medical Examiner must be notified at

or items

"natural"

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liny or other traumatic event ORB.

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

e Completed by Be 2 within 24 hours after death.

To the Funarai Director: After thi completely filled in by the funeral. Certification: Medicai

or Attending Physician: The law requires that the death certificate be executed

To the

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):
IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 24□ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown
Part II. Other significent condition	ns contributing to death but not resulting in th

25. Was case referred to medical

FEB 16 2007

3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Munknown
	24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 25 No
26. Place of Deat	th (Check only one)
ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred

	1 ☐ Yes 2 □	No F	lospital: 1 vlnpatient 2	ER/Outpatient 3[	DOA Other	Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
1 (	Manner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? 1 \( \text{Y} \)		28d. Describ	e how injury occurred			
	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	actory, office	ry, office 28f. Location City or To		(Street and Number or Rural Route Number, own, State)				
29	a. Certifier (Check only one)	1X Cartifying Phys 2 Madical Exami	sician: To the best of my knoner: On the basis of examinating and manner stated.	owledge, death occu ation and/or investig	urred at the time ation, in my opir	date and place ion, death occ	ce, and due to the	e cause(s) and manner as stated. e, date and place, and due to the ca	use(s)		
291	b. Signature and	title of certifier	) _		29c. License	umber		29d. Date signed (Month, Day, Ye	ear)		
			$^{\prime}$		D5818	2		2-12-2007			

State Registrar

13

C.DONALD GEORGE, MD 3001 HOSPITAL DRIVE CHEVERLY, MD 20785 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty 3. Time of Death **Physician** Katherine Wallech Year /Medical Feb. 16, 2007 9:00p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Nursing Center Hagerstown, Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 1935 Euray, VA 9. Birthplace (State or Foreign 220-54-4458 1 □ M 2 1 F 72 Days Hours Director Yrs. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 Ia marked other than "natural", or Itema 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits MD Washington Hagerstown, Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13403 Resh Road 21740 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Spewhite 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 No Specify: Completed ?7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 11th grade College (1-4or 5+) residence Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Marvin T.Sours Mildred F. McMichael ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmert B.Wallech 13403 Resh Rd. Hagerstown, MD 21740 spouse other 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Feb. 21. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò Department of Important: If any injury or once. Cedar Lawn Cem. Hagerstown, MD 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral HomeInc ▶ Minde Mily 23a. Part1. Enter the disease complications that wised the death. Do not enter the mode of lying, such as cardiac of respiratory arrest, Approximate shock, or hear failure. List only on a wise of each line. Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death **Physician** /Medical Due to (or as a consequ Examiner 0 ab Sequentially list conditions, Examiner dany leading to innivediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit malnul resulting in death) Last Due to (or as a consequence of): Box 68760, physiclen Physician/Medical use as the the attending IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy ŏ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Month Day Year detached 9□ Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? MCH page 2 should peen 1 Yes 2 No 3 Probably 4 Unknown certificate hes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 Z No 1 Yes 2 🗆 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After 28b. Time of Injury 28c. Injury at Work? 1 Natural 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director; A investigation the 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9060396 12/19/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ofal C 1126 3H-2 FAR: D MUNSHED MO Hogersdown MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Pegistrar's Signature

FEB 2 0 2007

			For State Registrar	state of Maryland /	-	rtment of He tificate of E			ene 200	7 06379	
ı	Physicia	an	Decedent's Name (First, Middle, Last)     Emma Jane Williams					2. Date of Death	Day Year	3. Time of Death	
	/Medic Examin	4	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death	repruary	19 200 1 4c. County of Dea		
	Examin	er	Washington County H			Hagers			Washington		
ŀ	Funeral Director		215-20-8827	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/13/1	9. Bir 916	thplace (State or Foreign ountry)  MD	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	cation		ů.		10d. Inside City Limits	
	Maryla f sho	tor	MD Washington	ı Ha	gerst	own				1 XYes 2 No	
	n with the	al Director	10e. Street and Number 46 Bethel Street			10f. Zip Code 21740		10	ng. Citizen <i>o</i> f What Co	ountry?	
036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdical Examiner must be notified at	by Funeral	11. Marital Status 12.  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: B	te, etc.	
215-0036	within 72 ho iene. than "natur he Medical I	Be Completed	15. Decedent's Educati (Specify only highest grade co	on 16 ompleted) College (1-4or 5+)	6a. Deced (Give life. D	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of work	ing	16b. Kind of Business		
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Maryland	ould be f Mental I narked of	To Be	James Russell Willi	.ams				Olivia l	,		
Mary	nd 2 sho Ith and I 27 is me r traume	·	19a. Informant's Name/Relationship (Type. Cynthia A. Smothers						City or Town, State, vn, MD 217	.*	
Baltimore,	ges 1 ar it of Hea if Item:		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem	loval from State		sition (Name of natory or other place	1		20c. Location - City or		
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ñ	permit Depart Import any In		13-4						gerstown,		
	Physician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition	cause on each line.	o not ente	er the mode of dying	g, such as cardiac	Fau	luge	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):	al Pu	reason	anie		Fen day	
	uted d ansit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ascential	Due to (or as a consequence of the second of	te oi).	e de Dec	pVen	Thro	breis	Several Da	
60,	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	ce of):	Calı	tis 40	HA.	einia	Serveres	
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S, P	ires that the de signed by the a be detached t	by	Part II. Other significant conditions contril	buting to death but not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did tob		o the cause of death?	
Corc	w require been signatures	leted	Coreix	roma of	11-	teams	1. ( bg 1/	24a. Was ar	24b. Were a	utopsy findings available	
Vital Records,	Physician: The law this certificate has traidirector, page 2 s	Completed			•			autops perform 1 Yes 2		completion of cause of	
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Division or	or Attendatter death Director: in by the	Certification:	Accident investigation    Accident investigation	28e. Place of injury - At home, building, etc. (Specify)	, farm, stre			28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,	
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	To the within To the compl	Me	29b. Signature and title of certifier			29c. License			od. Date signed (Mon		
7			30. Name and address of person who com	pleted cause of death (Item 23	a) (Type,	Print)	0-16		- 19-0		
\$/ •	4-4	•	31. Date filed (Month, Pay, Year) FEB 2 0 200	32. Registrar's Signature		22 04	VAL	T. TA	-SERSTE	7 520N MD 21740	
	Sta Registr		FEB 2.0 200	77		1				21/40	

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, 2007 February 9:30 Simon Russell Wright 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett Cherry Hill Assisted Living Accident If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1914 West Virginia 1 X M 2 □ F 214-01-9736 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Garrett Accident 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 303 S. Main St. 21520 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Blanche Messenger Simon Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1684 Friendsville Rd., Friendsville 21531 Gordon Wright/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Blooming Rose Cemetery Feb. 18, 2007 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A. Dazun Elma P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Week Preumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year

**Physician** /Medical Examiner

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Director: ,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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**Funeral** 

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Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiane.

and: If item 27 ie marked other then "natural; or Iteme 23a or 28a-f show the transition to the then that or other transition or the file and the rotified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pulnonoly disease 1 XYes 2 No 3 Probably 4 Unknown Be Completed cardiovoscylor 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cere Provisculor dis ease 1 Yes 208No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) assisted ٩ 1 ☐ Yes 2 No 28d. Describe how injury occurred liking 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of compar

State Registrar

31. Date filed (Month, Day, Year) FEB

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MB aumann 32. Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 247. Accident MD 21520

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MO M			1 ☐ Burial 2 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State I	-	natory or other place re Crem.	1	4/2007	Cambridge,	MD
Baltimore,	2 0 0 0 m	13	2. Signature of Funeral Service Licensee	701732	22	Name and Address	s of Facility	Microsoft and the second		
m	permit Depar Impor any ir	1	Cesee furran for	xevel	2 3	lia Snore 1272 Hudsc	Cremati	on Center Cambridge	P.O. Box	1464,
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	- > P O		VIII Olly mi	7		DOW	755 B	(	John.	4. 2000 -7
			30. Name of a dress of erson who completed calls	e of death (item 23a	) (Type, I	Print) , ,	0000			111
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DHMH 17 Rev 1/2001

07-01393 Betty Watson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 06382 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner February 19, 2007 Betty Lea Ellen Watson 1055 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death 3306 Main Street Apt 1 Manchester Carroll 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 7. Age (In yrs. last birthday) Months Days Director Hours 212-94-4212 1 M Country) 2 X F 29 07/17/1977 Usual Residence of Decedent 10a. State any 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1 X Yes 2 No items 23a or 28a-f shoust be notified at once. MD Carroll Manchester Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 3306 Main Street, Apt. 21102 United States Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Examiner must be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Yes 2 X No 9 Specify: White 4 X Divorced If Yes, Give Year Widowed Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or other traumafic event, the Medical Examiner. 1 Yes 2 X No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l and Mental Hygiene. Homemaker Residence 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Edward Leroy Watson, Sr. Cathy Ravenscroft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cathy Eggers - Mother 3306 Main Street, Apt. 1, Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Glen Haven Mem. Park 2/23/2007 Glen Burnie, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home, 934 South M00723 Main Street, Hampstead, Maryland, 21074 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Mixed drug (heroin, methadone, and ketamine) intoxixcation and Death Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): cocaine use Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician a the burial -X UNPENDED <sup>AMELOED</sup>, 27, 28a-f, perME, C865, 3/7/07 TT death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth signed by the attending be detached for use as t Ectopic pregnancy Fetal death Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records. plnous peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page this certificate Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes ဥ No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 X No Fnd 2/19/2007 | Fnd 10:50 am unk. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3306 Main St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 📗 6 X Could not be Suicide determined (Specify) found at home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical

WSL 0

30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

32. Signature

2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 20, 2007

Registrar

State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a=f per me 2865,03/21/07dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year BETTY WOOD Η. FEB. 12 2007 1:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F 86 Yrs Director 136-12-5296 OCT. 5, 1920 NORTH CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1K Yes 2 No MARYLAND WORCESTER BERLIN Direct 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? ö 1 MEADOW ST., APT. 217 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify: Specify: à WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Sumame! permit. Pages 1 and 2 should be Department of Heelth and Mental Himportent: If item 27 is meany injury or other Be h and Mental h SARGENT DUFFIELD AGNES ABSHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 STRAWBERRY CT., CLIFTON PARK, NEW YORK BETSY A. SCHALK/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 2/13/07 DELMAR, DELAWARE 21. Signature of ral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that aused the shock, or heart failure. List only one cause of each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) End Stage Rend Disease **Physician** /Medical Examiner Crastrointestm.1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € 100 Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Spine Fractures, Congestive heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidism Arrhythmin, has autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Mapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 Yes 2 this 28b. Time of Injury Unk Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1- Matural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide efter death Director: / investigation - 67 EDEN MONTH Subject fell 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number City or Town, State Atlantic General 4 Homicide 0 Hospital within 24 hours e To the Funeral C TERLUY. Medical 1.7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number 2/12/2007 H0064428 12en Amola DO 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) beneral Hospital 9733 Healthway Drive Berlin, MD 21811 Jusen Szymala DO 32. Aegistrar's Signature 31. Date filed (Month State Registrar

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			For State Registrar	State of Ma		epartment Certificate				ene) g. No.	07		384
E.			1. Decedent's Name (First, Middle, Last,	1					2. Date of Death Month	Day	Year	3. Time	of Death
	Physicia /Medic		Roma Boswe	ell Wi	nkleman				Februar		2007	3:2	5 <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give 5428 Cherry Hill			,	own, or Loc Lisbur	ation of Death			y of Death		
	Funeral Director		5. Social Security Number 6. Security Number 10		(In yrs. last birtl	nday) If Under 1 Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 11/27/1		9. Birthpla Countr Virg	y)	or Foreign
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	inylan show	_	10a. State 10b. County		10c. City, Town						10		City Limits s 2 🔼 No
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	with th	Ö	10e. Street and Number 5428 Cherry Hill I	200		10f. Zip 0			10	ig. Citizen of USA	What Countr	у?	
	eath ne 23	eral		12. Was Decedent E	ver in U.S.	13. Was Decede		nic Origin? (Spe	acify Yas or No-		ice - America	n Indian.	
36	itled within 72 hours atter death with the Maryland Hyglene. ther than "natural", or Iteme 23a or 28a-f ehow thit, the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes, specif	y Cuban, M	exican, Puerto	Rican, etc.)		ack, White, et	tc.	
8	2 hou	ed	15. Decedent's Edu	cation	16a.	Decedent's Usual	Occupation	375	. 1	6b. Kind of I	Business/Indu	stry	
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Maryland 21215-0036	uld be file fental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Last) Lenzie Boswell Sr	·			18.	allie (	e (First, Middle, M Carter	aiden Suma	me)		
, Mary	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show amy injury or other traumatic event, the Madical Examinat must be notified at ance.	15	19a. Informant's Name/Relationship (Ty Leonard Winkleman/						al Route Number, e, Salis				Ý
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Вох	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 3 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic pre 5 ☐ Other (spec				1	ate of delivery lonth E	/ Day	Year
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tal		e l	25. Was case referred to medical	-			26	Place of Death	1 Yes 2		1 ☐ Yes 2	ILI NO	
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Division of Vital Records,	or Attendestrende Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, far . (Specify)	m, street, factory,	office		28f. Location (Str City or Town,		ber or Rural	Route Nu	mber,
Ω	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	sician: To the best of	f my knowledge.	death occurred at	the time, d	ate and place.	and due to the ca	use(s) and m	nanner as sta	ted.	
	P Fur	edical	(Check only 2 Medical Exami	iner: On the basis of and manner sta	examination and	Vor investigation, i	n my opinio	n, death occurr	red at the time, da	te and place	, and due to t	he cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License nu		29	d. Date sign	ed (Month, D	ay, Year)	
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å	Fra	33	30. Name and address of person who co		eath (Item 23a) (	Type, Print) 5 - DI VISIO	u s	MIT	SAZISA	VAC	MD 2	160	4
4	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature								
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Registrar

Ashviii 31. Date filed (Month, Day

Patel 2007 102 Paul Mellon Court Suite 102 Waldorf, MD 20602

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 200 :30 Frances Almedia Weller ebrugry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 🖫 F 235-28-3713 81 26,1925 Director November PA Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Washington Hancock 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6 West Main Street 21750 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bar Tender Tavern 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Katherine Harris ပ William Harris Weller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16814 Alcott Road Hagerstown, James W.McPeak/Son MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Lawn MemorialPk 02/24/07 Hagerstown, MD 21. Signature of Funeral Se 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the l IF FEMALE for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Funeral PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10022043 0 ause of death (Item 23a) (Type, Print) IMGELSTOUNU 0

State Registrar 31. Date filed (Month,

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e**g**trar's Signature

		•	For State Registrer	State o	of Marylar	•	artment rtificate			and M	lental Hy	giene Reg. No.	7 11 11 7	063	887
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	Physici /Medio				Lee Wil	es	•				Februa		3, 2007	1025	A <sup>M</sup>
j.	Examin	er	4a. Facility Name (If not institution, giv	e street and nu	mber)		4b. City, To		Location o	of Death		4c.	County of Dea	ith	
			Union Hospital  5. Social Security Number 6.5	Sex	7. Age (In yrs.	last birthday)	Elk If Under 1	ton	If Under 2	24 Hrs.	8. Date of Bir	th	Cecil	thplace (State o	r Foreign
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3	2		Usual Residence of Decedent			-							, ,,,,,		
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4000	ms 2	nera	11. Marital Status		edent Ever in U				spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Am	erican Indian,	
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			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that one cause on e	caused the deat each line.	th. Do not ent	er the mode of	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Bety	veen
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Box	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live t	ointh 2 ☐ Feta nant at time of c	aldeath 3	Ectopic preg					2	3d. Date of de Month		'ear
o }	by the stached	hysi	1 ☐ Yes 2 ANo 9 ☐ Unknown	9□ Unkn				,							
ecords, P.O	igned t	by P	Part II. Other significant conditions	ontributing to d	eath but not res	sulting in the u	nderlying cau	ıse giver	n in Part I.		23e. Did t	obacco u	se contribute to	o the cause of de	eath?
ecords,	been sig	ted	_COPD								10	res 2	No 3∏P	robably 4 U	Inknown
ပို့ မိုင်	as be	Completed	Denestra	2							24a. Was	Sy	prior to	utopsy findings a completion of ca	available ause of
ž į											perfo 1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	_	
Vital	certifi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		15010		Other	r-		(Check only o				
Vision of Vita	ar this eral di		1 ☐ Yes 2 Ø No 27. Manner of Death		Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time of		c. Injury Work	4 🗆 Nui		ne 5∐ Resi 28d. Describe l		Other (Spe	icify)	
	death. ctor: After y the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		tn, Day Year)	Injury	М		es 2 N	No					
Division	after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place	of Injury - At h	ome, farm, str	eet, factory, o	office			28f. Location (. City or To	Street and vn, State)	Number or R	ural Route Numi	ber,
<u>۽</u> د	urs af		00-0-41												
3	within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier  (Check only one)  1 Certifying Properties  2 Medical Exercises	nysician: To the miner: On the b and man	e best of my kno easis of examina ner stated.	ation and/or in	vestigation, in	the time	e, date and inion, deat	h occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated.  to the cause(s)	
, L	withir To th comp	Me	29b. Signature and title of certifier				29c. L	License	number	_		29d. Date	signed (Mont	h, Day, Year)	
)	4		Cloboye	nul	>_		100	000	760	75	6	2	123	107	
	N		30. Name and address of person who	completed caus	se of death (Iter	п 23а) (Туре,	Print)	10	( =	1 ~	20:0	c./	CIL	(min	20
-			31. Date filed (Month, Pay, Year)	OK ≥	CO (O)	C(/)		40	U	111	(de)	7 /	CIK	100111	W
	Sta Registr		MAR 1	2007	4000		- ales								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:30 P Harry David February 28, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Dulaney-Towson Nursing Facility Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex ★ M 2 F 8. Date of Birth (Month, Day, Year) Jan. 14, 1929 Birthplace (State or Foreign Gountry) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** PA 78 Yrs 181-22-8542 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show treumetic event. The Madical Examiner nast be notified at 1 Yes 2 □ No Baltimore Maryland N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21205 1113 Quantril Way or items 23e Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 MYes 2 No
If Yes, Give KOTEAN
Year or Dates On flict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iten any injury or other treumetic event, the Madical Exertines, once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Union Elementary/Secondary (0-12) College (1-4or 5+) Local 24 Electrician 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Breinek Maru Walter I. Batz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Spangler Way, Baltimore, MD 21205 (brother) Walter Batz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3/3/2007 Baltimore, Maryland Oak Lawn Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 21 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ★ ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier A Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier D-0012849 OSLER Dr. TOWSON MD 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,MD

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

MAR 02

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene/ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2300 M 27 2007 february Dorothy M. Bridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 21XF 88 Director 716-18-0793 Sept. 22,1918 Pennsylvania Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mantal Hyglene. Department of Heelth and Mantal Hyglene. The propertiest if Item 27 is marked other then "naturel", or Iteme 23s or 28s-f ehov eny injury or other traumatic event. Its Mudical Examinat must be notified at QDEs. 1 X Yes 2 □ No Hamilton Director New Jersey Mercer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 08620 U. S. A. 9 Toby Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 X Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis R. Carroll Mary J. Ragan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Jaeger (Daughter) 1402 Marlow Court, Bel Air, Maryland 21014 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c Location City or Town, Sta Ewing Township, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ewing Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2007 New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** /Medical Due to (or as a consequence of): Examiner nevosci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transl Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached for 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Kusion Supraventucala 1 Tes 2.XNo 3 Probably 4 Unknown potnyroid 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an performed? 1 ☐ Yes 2 No certificate Vitál 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient ٩ 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ō 1 Certifying Physician: To the bast of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 441069

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State 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cau

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3 Registrar's Signatur

8 BUSINESS CT MY Edge wood

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of death (Item 23a) (Type, Print)

Registrar

			For State Registrar	State of M	larylan	-	artment of H		ınd Men		ene 00	7	063	90
	G		1. Decedent's Name (First, Middle,	Last)	-					Date of Death		Year	3. Time of	Death
	Physicia /Medic		Cecelia	Н.		В	ielik			urch 1,	2007	Teal	2:30	$P^{M}$
}	Examin		4a. Fecility Name (If not institution,		7)		4b. City, Town, or		4c. County of Death					
٠			Riverview Care C				Essex	T If Hadas 0	14 Hen Ta		Balti			
	Funeral Director		217-01-0633	5. Sex 7. A 1 □ M 2 💢 F	ige (In yrs. 1	1 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day, Lrch 10	Year) ,1915	Coui	olace (State on otry) yland	r Foreign
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside Cit	y Limits
	Mary -fah	to	Maryland Baltim	ore		Dunda	lk						1 🗌 Yes	2 <b>∑</b> No
	h the	irec	10e. Street and Number	.020		Durida	10f. Zip Code			10	g. Citizen of W	hat Cour	ntry?	
	23a c	aiD	3117 Shortway				2122	22			USA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healin and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28e-f ahow if it item 27 is marked other than "natural", or items 23a or 28e-f ahow or other traumatic avent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ※ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces d 1 □ Yes 2X If Yes, Give Year or Dates	? ] <b>N</b> o		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Orig in, Mexican, Specify:	gin? (Spe <i>c</i> ify ` , Puerto Ricar	Yes or No- n, etc.)		c, White,	ean Indian, etc. ite	
9	72 hou		15. Decedent's				dent's Usual Occupa		of working	10	6b. Kind of Bu	siness/In	dustry	
21	ithin 7 le. len "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	)		_				
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and	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, the Me	Be	17. Father's Name (First, Middle, La Walter Kowalczyk	•					rs Name (Firs		aiden Sumame	9)		
Ĕ	should be fund Mental H s marked of umatic aver	မ	19a. Informant's Name/Relationshi			19b Mailir	ng Address (Street a				City or Town 5	State Zin	Code	
<u>≅</u>	id 2 s Ith an 27 is i	. 19	Mary Szrom	Daughter		1	Shortway,					_	(0006)	
<u>6</u>	f Healthern		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other place		arch 5		0c. Location - (		wn, State	
E O	Page: ent o nt: If ry or		1 XBurial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe				ry Cemete	ry	2007		oundalk,	, Ma	ryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra once.		21. Sin ature of Funeral Service Li	censee	>	č	Name and Address Onnelly F 110 Solle	s of Facility unera	1 Home	of Du	ındalk,l	P.A.	21222	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	ed the deeth		er the mode of dyin	g, such as c	cardiac or res	piratory arres	st,		Approximate Interval Bety	
	Physician		Immediate Cause (Final disease or condition	Sus	peck	ed l	ung (	Bance	ir his	H m	Kaska	ses	Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):								
	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or a	s a consequ	uence of):		÷						
1	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or a	s a consequ	uence of);								
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89	ifficati g phy as the	ledic						,						
Вох	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnancy				23d. Date		-	
P.O. E	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant : 9□Unknown			Other (specify)				Mon	tn	Day Y	ear
ص	res that the de igned by the a be detached f		Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use contri	bute to th	ne cause of de	eath?
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ita		Be C	25. Was case referred to medical examiner?					26. Place	of Death (Che				22110	
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U C	ing P	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	Worl	ζ?		Describe how	injury occurre	d		
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Division of Vital Records,	il or Attend after death   Director: / d in by the f	Certification:	4 ☐ Homicide determin	ed 286. Place of II	etc. (Specify	me, rarm, str	eet, factory, office			City or Town,		r or <b>mura</b>	i Houle Numi	oer,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	-	29a. Certifier 1 Certifying	Physicien: To the bes	t of my kno	wledge, death	occurred at the tim	ne, date and	f place, and d	lue to the cau	ise(s) and man	iner as st	ated.	
	he Ho in 24 t he Fu pletely	edic	(Check only 2 Medical Exone)	caminer: On the basis and manner s	of examinal stated.	tion and/or in	vestigation, in my op	oinion, death	h occurred at	the time, dat	e and place, a	nd due to	the cause(s)	
	To the within 7 to the comple	Σ	29b. Signature and title of certifier	M.P			29c. License	number	201.	290	Date signed	(Month,	Day, Year)	7
7			P NW				1 1.	- 50	124		,	, *		
	2		30. Name and address of person w	1 ASBB	n.	70	9. BAS	TER	en o	BLUD	, M	D-	2122	-1 .
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			For 1 - State Registrar	State of Maryla	nd / Depa		of H	ealth a				007	06391
			Decedent's Name (First, Middle, Last)							2. Date of De	eath		3. Time of Death
	Physici /Medio		MArtha L. E	ell						Feb	25	′ 20ď7°	9:47a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	Town, or	Location o	f Death		4c.	County of Death	1
		*	Ivy Hall Nursi					ddle	Riv	ver	В	altimo	
	Funeral		5. Social Security Number 6. Security Number 1 6. S	7. Age (In yr.	s. last birthday) 6 Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bi	rth ay <i>Year)</i> 130	9. Birth	place (State or Foreign untry)
	Director		Usual Residence of Decedent							11111 01.	130,	Ma	aryland
	yland yland		10a. State 10b. County		City, Town or Lo								10d. Inside City Limits
	Mar Milled	ctor	MD Balti	more	Middl	e Ri	ver						1 ☐ Yes 2 🙀No
	h with the 23a or 28 at Le no	Funeral Director	10e. Street and Number 102 Covered Wa	gon Road		10f. Zip (	Code 122	0			-	izen of What Cou SA	untry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Evariance must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede f Yes, speci 1 Yes 2			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify: W	
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	iled w dygier iher ti	S	12th 17. Father's Name (First, Middle, Last)						r's Namo	(First, Middle	Maiden	Sumame)	
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ary	should ind Men marke umatic	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address	(Street a					r Town, State, Z	p Code)
	and 2 salth a n 27 is		Frederick C. B	ell /broth	er 10	2 Co	ver	ed Wa	agor	Road	Ba:	ltimore	e MD
Baltimore,	Pages 1 and the part: If item		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cometer, cren aK Law	sition (Naminatory or oth M Cel	e of her place Mete	ery :		o 7		cation - City or 1 ltimore	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service License	Cornel	$\int_{\mathcal{C}} \int_{\mathcal{C}}^{22}$	Name and	Addres	s of Facility Fune	300 eral	Mace Home	Ave	e. Balt Essex	imore MD 21221
п			23a. Par(1. Enter the disease, or compleshock, or heart failure. List only pr	cations that caused the de le cause on each line.	ath. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	ırrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):								1
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89	tificat ng phy as th		The second secon										
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	Ectopic pre Other (spe						23d. Date of delin Month	rery Day Year
S, P	res that signed b		Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	ndertying ca	use give	n in Part I.			tobacco u Yes 2[		the cause of death?
oro	w requir been si should	eted	Darking	, a cool	970	<b>V V</b> )							
Il Records,	The lay ate has page 2	Completed by	- Fantin 13am	s and	, ,					24a. Was auto perfo	psy ormed?_	24b. Were aut prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			Othe			(Check only	,		
of Vital	Phys this ral dia	. To	1 ☐ Yes 2 ☑ No	1 inpatient 2	_		Α.	4 ( <u>1</u> ) Nul		ne 5 🗌 Resi 28d. Describe		Other (Spec	ify)
Division	Attending or death. sector: After by the funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	3c. Injury Work 1 🔲 Y	? ′es 2 □ N				,	
Visi	I or Attendi after death. Director: A	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory,	office		2				al Route Number,
Ö	s afte	Cert	4   Nomicide	building, etc. (Spe	сну)				10	City or To	wn, State	,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certification;	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death	n occurred a vestigation,	it the tim in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To t withi To t	Ň	29b. Signature and title of certifier	M.D.		29c.	D-	number 38	75	4	29d. Dat	e signed (Month - 2.6	2007.
	9		30. Name and address of person who po	ompleted cause of death (It	em 23a) (Type,	Print)	BA	1571	BRA	1 BL	UD,	MI	1-21221
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	alle s							
			MAK U & CUL	JANEAN S	1500	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month Anaeline Bosle 640 AM Feb 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA University of Maryland Medical Battimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)
Feb. 23,1925 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 ☐ M 2 🛣 F Months Days Feb. Pennsylvania Director 217-18-5223 82 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 110 Locust Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify <u></u> 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Dimattia Anna Gabrielli 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Bosley Son 115 Rosewood Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Metro Crematory 3/3/2007 Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sarvi 101290 1630 Edmondson Avenue: Catonsville, MD 21228 2. Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been sit , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No ို 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Naturat Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: I hours after death.

Certification: filled in by the Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 419667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South ( 32. Registrar's Signature Baltimore, MD 21201 31. Date filed (Month, Day, Year) Brown Govern State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

28, 2007

	T = For State Registrar  1. Decedent's Name (First, Middle, La	State of Marylan		tificate of			eg. No.	/ 0539			
ysician Medical	Frank Richardson  4a. Facility Name (If not institution, giv	Benson, Jr.		45 0% T		Month Februar	y 25, 20				
eral	1910 Griffis Ave 5. Social Security Number 217-54-3939	•	last birthday) Yrs.	Bal	or Location of D  imore  r   If Under 24 I  s   Hours   N		4c. County of n/a n/a 9 49				
other traumatic event, trampleted Examinar most be nutified at	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Lim			
i Director	MD n 10e. Street and Number 1910 Griffis Ave	/a	В	altimore	21230	1	0g. Citizen of Wha	1 MYes 2 □ I it Country? USA			
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1	Vas Decedent of Yes, specify Cu	Hispanic Origin? ban, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race -	American Indian, White, etc. White			
Completed	15. Decedent's Ec (Specify only highest gra-	ducation de completed)  College (1-4or 5+)	(Give . life. [	ent's Usual Occi kind of work don OO NOT use retii	eduring most of ed)	working	16b. Kind of Busin	ess/Industry			
To Be C	17. Father's Name (First, Middle, Last, Frank Richardson		Dari	<u> </u>	18. Mother's	Name (First, Middle, M	Maiden Sumame)				
	19a. Informant's Name/Relationship ( Mrs. Dorothy L. B 20a. Method of Disposition	enson / Wife	1910	g Address (Stree Griffis sition (Name of natory or other pi	Ave. B	altimore, Date		21230			
ODCE.	1, Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifications)	Lou	don Pa	rk Ceme	tery 3/	Loudon Par	k Funera				
n al	23a Part Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		n. Do not ente	r the mode of dy	ing, such as card		est,	Approximate Interval Between Onset and Death			
dedical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):										
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										
þ	Part II. Other significant conditions of	ontributing to death but not resu M 2011 Lus	alting in the un	derlying cause g	iven in Part I.			te to the cause of death?  Probably 4 TUnknow			
e Completed	25. Was case referred to medical						prior deat				
00	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	2000		Death (Check only one					
Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 🗆 Nursini	g Home 5 Reside 28d. Describe ho		эрөсну)			
	3 Suicide 6 Could not be determined	building, etc. (Specify	·)			City or Town	. State)	r Rural Route Number,			
Medical Ce	one) 2   Madical Exam	ysician: To the best of my know iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my	opinion, death or	ccurred at the time, da	and place, and	due to the cause(s)			
	30. Name and address of person who BICH DUNKE,	www.	232) /T 5	D2	6256		2/26/	2007			
,	BICH DUNG	724 Registrar's Signat	Mail	en Ch	oice La	1 Ball	imore.	MO 2122			

			1 - For State Registrar	State of Maryla	and / Depa		Health and	Mental H	ygiene Reg. No	2007	063
	Physic /Med Exam	lical	1. Decedent's Name (First, Middle, Las Josephine Mary 4a. Facility Name (If not institution, give Stella Maris	Barczak		4b. City, Town, Timoni	or Location of Dea		23, Day	2007 Year County of Deat	3. Time of 12:4
	Funera Directo		Social Security Number     6. S	ex 7. Age (In yi	rs. last birthday) 90 Yrs.	If Under 1 Yea Months Days	r If Under 24 Hr		Birth Day Year) -191		hplace (State or ountry) y Land
J. A.M.	death with the Maryland me 23a or 28a-f ehow Emust be notilised	rector	MD 10b. County  NO N N		City, Town or Lo				10g Cit	izen of What Co	10d. Inside City 1 X Yes
12:40	ĕ # #	by Funeral Director	3202 Batavia Av  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Jenue  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		21214	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	1	USA  14. Race - Ame Black, White	ncan Indian, e, etc.
2007	7 2 Tage	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	life.	lent's Usual Occi kind of work don DO NOT use retir Maker	ed)		Hor	ite Industry	
23,	Maryland of 2 should be file th and Mental Hy t7 1e marked oth treumatic event	To Be	17. Father's Name (First, Middle, Last) Frank Schultz  19a. Informant's Name/Relationship (7 Leonard Barczak	ype, Print)	19b. Mailir	g Address (Stree		Winied  Winied  Oural Route Number	cka ber, City o	ip Code)	
FEBRUARY	Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than eny injury or other treumatic event, Itam price.		20a. Method of Disposition  1 Date 2 Canal Service Licenses	Removal from State Sa	Place of Dispo cemetery, cren cred H	sition (Name of natory or other place)		5 <b>ºº</b> 7	20c. Lo	dalk, N	Town, State
V	Physician and Examiner partial stransit of par	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Julications that caused the de one cause on each line.  a. VA 3 C U i  Due to (or as a conse to or as a cons	equence of):	EMENT	Ä			re, mu	Approximate Interval Betwe Onset and De
	the deeth certification in the attending ached for use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 tb No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tel death 3 🗌	Ectopic pregnand Other (specify)	у		2	3d. Date of deliv	very Day Ye
h>	requires	Completed by P	Part II. Other significant conditions co	ntributing to death but not re	esulting in the un	derlying cause gi	ven in Part I.	1 🗆	Yes 2		bably 4 🗆 Uni
	VICA Bicien: Certifice rector, p	To Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No	Hospital: 1 ∐Inpatient 2〔	□ ER/Outpatient	o Ott		auto perfo 1 ☐ Yes ath (Check only o	psy ormed? 2 No one)	1 ∐ Yes	
BARCZAK	Jn C	Certification; T	27. Manner of Death  1 Matural  2 Accident  3 Suicide  4 Homicide  5 Pending investigation  6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At I building, etc. (Spec	28b. Time of Injury	28c. Inju Wo M 1	4 Log Nursing F ry at rk? IYes 2 □ No	28d. Describe  28f. Location ( City or Tot	how injury		
	To the Hospitel or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical C	one)  29b. Signature and title of certifier)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the tiestigation, in my o	opinion, death occu	erred at the time,	date and p	and manner as s place, and due to signed (Month,	o the cause(s)
	V		30. Name and address of person who co Corazon Soares, i	ompleted cause of death (Ite		DIG		TIMONIUM		2109	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 2 200	32. Registrar's Sign	and the second	4					

BARCZAK, JOSEPHINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06395 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** 5:25 PM Cole, III 28 Edward J. 1-eb 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES BALTIMORE HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 □ F Director 8-28-1958 Pennsylvania 217-72-6110 48 Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a dical Exaπlner must b 106 Lahinch Ct. 21108 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married TY Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Roofer E & J Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward J. Cole, II Nadine Bender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Cole- wife 106 Lahinch Ct., Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 03/05/2007 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dma ll Cel CANCER unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Physician: The law 24a. Was an autopsy performed Vital 2 12 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To 0 this funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 ☑ Natural 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No n 24 hours after death.

e Funeral Director: A
letely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0002500 Feb 28,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETIENNE NGOUMONA 900 CATON Avenue BALTIMORE, MO 21229 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 02 2007 Registrar

DHMH 17 Rev 1/2001

DERACE

			1 - State Amend #19a	State of M Per FH	aryland /	Pepal Cert	rtment of Herificate of L	ealth a Death	nd Mental Hy	/giene Reg. No	007	06396
			1. Decedent's Name (First, Middle, Last)						2. Date of D			3. Time of Death
	Physici /Medic		Annie Mae Davis						Marci	w I	2007	450 am
	Examin		4a. Facility Name (If not institution, give	street and number)	1/	11	4b. City, Town, or	Location of	Deathy /	4c.	County of Death	
			Maryand bi	eneral	HOSPIT	al	Bublin	PORCE	Corry			
	Funeral		5. Social Security Number 6. Sec	7. A	ge (In yrs. last b		If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of B Min. (Month, D	irth ay, Year)	9. Birth	plece (State or Foreign ntry)
	Director		216-42-5556	, M 2 <b>X</b>	90	Yrs.			06/24/	1916	Nort	h Carolina
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	ation				1.	10d. Inside City Limits
	Aaryii Feho	5										1∰Yes 2 ☐ No
	the 28a-	Director	Maryland 10e. Street and Number			Balti	More 10f, Zip Code			10g. Cit	izen of What Cou	ntry?
	Sa or	□	501 West Franklin	Street			212	Λ1			U.S.A.	
	ma 2;	era		12. Was Decedent	Ever in U.S.	13. W	as Decedent of His	spanic Origi	in? (Specify Yes or N		14. Race - Ameni	
(0	of the	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give					Puerto Rican, etc.)		Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  od other than "natural", or items 23e or 28e-f ehow avent, the Medical Examinat must be notified at	by	3 ₩idowed 4 Divorced	Year or Dates:			□Yes 2X No	Specify:			Specify: Bla	.CK
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		16	(Give ki	ent's Usual Occupa ind of work done d	uring most	of working	16b. K	ind of Business/In	dustry
21	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. Do	O NOT use retired)	)	v			
2	filed w Hygier other tl		17. Father's Name (First, Middle, Last)				Housewif		la Nama /Cirat Middl		memaker	
and	be fi	Be						to. Motrier	's Name (First, Middle	e, maideri	Sumame)	
ž	should be nd Mental marked o imatic ave	7	John Jones	na Drint)	1/	No. Mailine	Address (Ctroots		ie Miles or Rural Route Numi	has City	Town Ctata Ti	Codel
Maryland	12 sh h and 7 Is n traun		19a. Informant's Name/Relationship (Ty	, Dau	ghter	VIVO 19904	2003 SSW					
	1 and Healt em 2		Lillie M. Richards 20a. Method of Disposition	on /-Sis	20b. Place	of Disposi	ition (Name of		, Baltimor	0c. Lo	aryland cation - City or To	21201 own, State
10	nt of nt of t: If it		Marial 2 ☐ Cremation 3 ☐ F	lemoval from State	'		atory or other place	1	105 10005	ACIH-1		
Baltimore,	artme ortan injury		* 4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service Licen	<b>A</b>	I ME.	Z10n	Cemetery Name and Address	s of Facility	/05/2007	Land	sdowne,	Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 Is marked any injury or other traumatic a <u>once</u> .		1			161	1 Dark U	ata	The Derric Ave., Balt	K C.	Jones F	/H, P.A.
			23a. Part1. Enter the disease, or compl	ications that cause	d the death. De						e, Mu. Z	Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each I	ine.	× ×.	leart	En	kir.p			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to Las	a consequenc	/ / /	XXX Y	1 al	Torce			
	Examiner											
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequenc	e of):						
W.	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events	).								
8760, 5	e exe ian a urial-	Ä	resulting in death) Last	Due to (or as	a consequenc	e of):						
876	cate b physic the b	dlcal		d								
9		Mec	IF FEMALE:	0 - 11						I	1	
Вох	leath certifi attending	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pregnancy			- 1	23d. Date of delive Month	ery Day Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of death	5 🗆 (	Other (specify)					
Ω.	The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death t	out not resulting	in the unc	derlying cause give	n in Part I.	, 23e. Did	tobacco u	ise contribute to t	he cause of death?
ds,	sign d be	d by	Acute Renal	Far/UK	e, D	rabe	etes M	With	US, 10	Yes 2	□No 3□Prob	pably 4 Denknown
Ö	w requir been si should	lete	Huppo Homeron	1)					24a. Wa	s an	24h Were auto	ppsy findings available
Record	The lav	Completed	AGREET CISION						auto	ormed?	prior to co death?	mpletion of cause of
		e Co	25. Was case referred to medical					GE Blace	1 ☐ Yes of Death (Check only	2/2 No	1 🗆 Yes	2□ No
Vital	Physician: this certific ral director,	o Be	examiner?	lospital: 1 1 Inpati	ent 2 FR/0	Outpatient	3□ DOA Othe	· ·	sing Home 5 Res		6 ∏Other (Specif	(v)
ō	g Phy er this eral d	-	27. Manner of Death	28a. Date of Inju	ury 28b	. Time of	28c. Injury Work		28d. Describe			77
ion	Attending I r death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	ay roar)	Injury		res 2□N	0			
Division	Atte er de recto by th	tffc	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, tc. (Specify)	farm, stree	et, factory, office			(Street an	d Number or Rura	al Route Number,
Ö	tal or rs afte al Dir	Certification:									, 	
	Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical Exemi	ner: On the basis of	of examination a	lge, death and/or inve	occurred at the timestigation, in my op	e, date and inion, death	place, and due to the	cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) 29b. Signature and title of certifier	and manner s	tated.		29c. License				te signed (Month,	
	Twi Fo		Alte				82	51X	9		21,1200	
				mploted source of	death (line on	) (Trans 12	07.	027	2	0	11/0/	/
	4		30 Name and address of person who co	1 MA		-an	mD. C	10 m	beryland	Gun	eral b	ospital
	Sta	até	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	1	M s	0 / /	1	0.017		1
	Regist		MAD 0 2 2007	Maria	a St.	CONTRACT.	A. J					

Maizie	Hightower	Delancey

	1- For State Registrar		Certifica	ate of l	Death		٦	F	Reg. No.	01 0039
Physician/ Medical Examiner	Decedent's Name (First, Midd	MAIZIE	HIGHTO	WER	DeLAN	CEY		Date of De		3. Time of Death 1222 hrs
	4a. Facility Name (if not institution Route 97 north of Route 97 north 07 n				. City, Town, o <b>We</b> stminst				4c. County o	f Death
Funeral Director	5. Social Security Number 225-34-5042	6. Sex 7. Ag	e (In yrs. last birti 77	hday) Yrs.	If Under 1 Ye Months Da				irth(MM/DD/YYYY) 1/1929	9. 8irthplace (State or Foreign VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a State  10b County  MD  CAR  10e. Street and Number  2806  RAINBO  11. Marital Status  1 Never Married  2 X M  3 Widowed  4 Div  15. Decedent's Education (Spe  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle	ROLL  W DR.  12. Was Decedent Armed Forces?  1 Yes 2 orced If Yes, Give Year or Dates: cify only highest grade con  College (1-4 or s)  BENJAMIN	Ever in U.S.  X No  poleted) 16a. E  ADI	or Location TMIN  13. Was I If Yes  1	STER  10f. Zip Code  2115  Decedent of H , specify Cuba  es 2 X No  Usual Occupat t of working life  STRAT	spanic Origin, Mexican, Mexican, o specify: ation (Give and DO NOT VE A 18.Mother'	gin? ( Specir Puerto Ric kind of work use retired) LSSIS is Name (Fir	ry Yes or No an, etc.) done TANT	USA  14. Race White, Specify:  16b. Kind of Bus  EDUCA'  Maiden Surname)  COLL	10d. Inside City Limits 1 Yes 2 X No at Country?  American Indian, Black, etc.  WHITE iness/Industry  PION  INS
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev	19a. Informant's Name/Relations  WILLIAM M. De  20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other St  21. Signature of Funeral Service	ELANCEY -HU	JSBAND 20b. Place o	2806 f Disposition or other UNTY 22. Nar	RAIN on (Name of cer place) CREMA	BOW I emetery, ATION s of Facility	DR.,V	VESTM ate /07 CHER	20c. Location - ( SYKESV FUNERAL	
Physician /Medical Examiner	23a. Part I. Efter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	on each line.	equence of).	t enter the	mode of dying	, such as ca	ardiac or res	WESTI	TINSTER est, shock, or hear	t Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death the Funeral Director: After this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transit dical Certification: To Be Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	c. Due to (or as a conse d.  AMENDED  23c. If yes, outcon 1 Live birth 4 Pregnant at	equence of):	Fetal Other	death 3	Ectopic	pregnancy		23d. Date of d Month	elivery Day Year
tal Records, P.O. rian: The law requires that the certificate has been signed by ector, page 2 should be detach  Be Completed by Pl	Part II. Other significant condit		n but not resulting	in the und			check only	1 Yes  24a. Was autop perfo 1 Yes	an 24b. We primed?	ute to the cause of death?  Probably 4 Unknown  ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Division of Vital Records, ta or Attending Physician: The law require rs after death and Director. After this certificate has been sided in by the funeral director, page 2 should bertification: To Be Completed	examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pend	Hospital: 1 Inpatie 28a. Date of Inju Feb 27, 2007	28b. T 1215		DOA  ry 28c. Inju	Other <sub>4</sub>	Nursing Ho 280 Dri	ome 5 Describe	Residence 6  how injury occurred auto collision	
Division o  Hospital or Attending 24 hours after death Funeral Director: After stely filled in by the fune al Certification:	4 Homicide deter	d not be	jury - At home, far jor Road / Hig v knowledge, deal	hway			Rou	or Town, S ite 97 nort	State) h of Route 32, W	
To con		miner: On the basis of exar and manner stated.				n, death occ se number			and place, and due	e to the cause(s)  (Month, Day, Year)
10		ssistant Medical Exa	miner 111	Penn S	treet, Baltir	more, MI	D 21201			
State Registrar	31. Date filed (Month, Day, Year) MAR 0 2 2	Registrar	's Signature	had	p					
DHMH 17 Rev 1/2001	•	_	ORI	GINAL						

			A FOI	partment of Health and Nertificate of Death		ne 007	06398
	Physici		1. Decedent's Name (First, Middle, Last) Daniel Daniels		2. Date of Death Month 03/1/200	Day Year	3. Time of Death 2:55 A M
j	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	2:35 A
	LAGITIII		5219 Ilchester Road	Ellicott City	H	loward	
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpl Coun	ace (State or Foreign try)
	Director		212-46-9069 1 39		06/14/194		ngton D.C.
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
	Many -1 eh	ţō	MD Howard Ellicott	City			1 ☐ Yes 2 ☐No
	r 28e	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	d within 72 hours after death with the Maryland Jiele. I then "naturel", or Iteme 23a or 28e-f ehow The Medical Examinating the notified al	a	5219 Ilchester Road	21043		USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - America Black, White, of	
9	s afte	by Fu	1 Never Married 2 Married 1 M Yes 2 No	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	
9500-61212	hour	ed b	1967-69	edent's Usual Occupation	161	b. Kind of Business/Ind	
Ç.	n "na	plet	(Specify only highest grade completed) (Gi	re kind of work done during most of work DO NOT use retired)	king	o. Nara of Basingsanio	astry
7	d with	Completed	Elementary/Secondary (0·12) College (1-4or 5+)  12 Owner		Re	staurant	
2	be filed htal Hygi od other event, I	BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	den Surname)	
<u>X</u>	should that Ment	2	Unknown		. Daniels		-
Maryland	~ ~ ~			iling Address <i>(Street and Number or Ru.</i> D Ilchester Road, I			
altimore,	of Health of Health of Item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	position (Name of ematory or other place)	Date 200	c. Location - City or To	wn, State
Ĕ	Pages ment of tent: If it jury or o		4 Donation 15 Other (Specify) Metro Ci			tonsville,	
Egal Rail	permit Depart Import any In		21. Signature of Funeral Service Licensee  MO1378	22. Name and Address of Facility Fary L. Kaufman Fur 250 Washington Bly	neral Home /d., Elkri	e at MMP, I dge, MD 21	NC. 075
			23a Part 1. Enter the disease, or complications that caused the death. Do not a	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
) 1	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Widely MeTAS	TATIC LUNG CA	INCER		Onset and Death  3 YCARS
	/Medical Examiner		Due to (or as a consequence of):				
		-E	Sequentially list conditions, ff any, leading to immediate Due to (or as a consequence of):				
5-	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury			Ì	
5	be executed iclan and burial-transit	Exa	resulting in death) Last  C.  Due to (or as a consequence of):				
9/60	o × o	dicai		- w.		-	
Õ	leath certificate attending phys	Med	IF FEMALE:				
X Q Q	atter for u	lan	in the past 12 months?	☐Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
o i	0 00 0	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 3	Other (specify)			
J.	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	o use contribute to the	e cause of death?
vitai Records,	quires nn sign uld be	d be	Severe Emphysema. Con	DIDARY HEART	1 Pres	2 No 3 Proba	ably 4 Unknown
ပ္တ	law re as bee 2 sho	plet	Disease		24a. Was an	24b. Were autop	sy findings available
ř	The I	Completed by			autopsy performed	1? death?	piletion of cause of
<u>=</u>	cian: ertifica ctor.	Be	25. Was case referred to edical examiner?		th (Check only me)		
5	Physician: rthis certific ral director.	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		ome 5 Mesidence	e 6 ☐Other (Specify	)
_	5 5 5	ertification;	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury		28d. Describe how i	njury occurred	
DIVISION	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree. City or Town, S.	t and Number or Rural tate)	Route Number,
2	pital o	O					
	To the Hospital or Attending Physician: within 24 hours after death or To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To t Withi Comp	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
			HUMA ) ATTENDING MYSI	CIAN D16200	MI	ARCh 1, o	(007
	20		30. Name and address of person who completed cause of death (Item 23a) (Typ 720 C MAINE NO LOICE LANCE  31. Date filed (Month, Day, Year)  12. Registrar's Signature	a. Print) Dr. NORBEL	TO M. K	AACH IRAN	
	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature	of lowsome M	414 (1401)	01608	
3.	Registr	ar	MAR 0 2 2007	MEL!			

Registrar DHMH 17 Rev 1/2001

State

TARIO MAHMOOD

31. Date filed (Month, Day, Year)

11:05

27

Baltimore, FEBRUARY

P.O. Box 68760

Records,

Division or Vital

WILLIAM ERNST

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 negistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7 2007 O A **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOWARD HOWARD Columb GENERAL Co. Hospidai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 1 □ M 2 💢 F MANSAS Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits HOWAR 1 ☐ Yes 2 🕅 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U54 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORAtory HOSPITAL ス 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/04 19a. Informant's Name/Relationship (Type. Print) 10117SPRing Columbia MO HEIENA HUnt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) St AN ISIAU5 2 22. Name and Address of Facility 2-21-01 DUNGALT 21. Signature of Funeral Service Licensee AWEATHERFORD 2431 E. OINER 51 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 112/3/24 ORONAN Due to or as a consequent e of): DERTER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (er as Examiner Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 5 ☐ Other (specify) 4 □ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Leath 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed burial-trar Records, P.O. Box 68760, attending for detached After this certificate has or Vital

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

filled in by the funeral director, page 2: Hospital or Attending within 24 hours after death To the Funeral Director: completely

DHMH 17 Rev 1/2001

31. Date filed (Month; Day, State Registrar

Medical

29b. Signature and title of co

6 ☐ Could not be

4 ☐ Homicide

29a. Certifier (Check only one)

and manner stated.

29c. License number

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STO FROM 100 OF SULF 260

Columbia ano

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month

Porvary 27 L

4c. County of Death Year **Physician** 2:50 AM ne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City or Location of Death Examiner FINOR John Year | If Under 24 Hrs Birthplace (State or Foreign Country) cial Security Number Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1**½**M 2□F Months Days 38 Yrs. 218-78-1844 Director Jan 25,1969 Maryland Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show important: If Item 27 Is marked other than you of the traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2☐No Director MD Dundalk Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 635 Battle Grove Road 21222 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ₩ Wever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest S. Erdossy, Sr. Frances Tolodziecki ပ 19a. Informant's Name/Relationship (Type. Print)Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7635 Battle Grove Road Dundalk, MD 21222 Ernest S. Erdossy, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Mary 3-1-07|Dundalk, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 201 Dundalk Ave. Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4 days /Medical Due to (or as a consequence of) Examiner P. Th Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of Examiner i necords, P.O. Box 68760, C.
The law requires that the death certificate be execdled 1 mm mr vs and Due to (or as a consequence of): burial-1 Division or Vital Records, P.O. Box 68760, physician Se Physician/Medical ことした the Sas aftending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Vear 4☐Pregnant at time of death 5 Other (specify) ed by the at detached fo ☐Yes 2☐No 9☐ Unknown 9 Unknown been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2 MAR 0 2007

000 \$2. Registrar's Signature

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21287

			For State Registrar	State of M	aryland		rtment of H			•	giene Reg. No 2 0 0	7	061	+02
	Physic		1. Decedent's Name (First, Middle, Marie	B. Edward	is	<del></del>				2. Date of Dea Month Februar	ath	rear <b>07</b>	3. Time o	
	/Medi Examir		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of		T EDI UUI	4c. County o		1:30	<u>a</u> '''
٦			Oak Crest				Parkvi	11e			Balt	mor	e	
	Funeral Director		5. Social Security Number 214-12-8899  Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 ☐ XF	ge (In yrs. Ia 86	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Sept.	h, Year) 16, 1920	Coun	olace (State ontry) arylan	-
	/land ow at		10a. State 10b. County		10c. City	, Town or Loc	ation					1	0d. Inside C	ity Limits
	a-fsh ified≀	itor	Md. Princ	e Georges	Bow	ie							1 ☐ Yes	2 <b>∑</b> No
	ith the or 28	Director	10e. Street and Number		-		10f. Zip Code				10g. Citizen of Wh	at Coun	itry?	
	death with the Maryland ms 23a or 28a-f show r must be notified at	ral	3533 Madonna L					715				ISA		
VI.	je 42 g	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🔀		S. 13. W	as Decedent of Hi Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black,	Americ White,		
36	urs af al", or Exam	ρ	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	140	1	□Yes 2X No	Specify:			Specify:		Whit	e
7 5	72 ho	eted	15. Decedent's (Specify only highest	s Education grade completed)			ent's Usual Occupa		t of worki		16b. Kind of Busi	ness/Inc	lustry	
Q 2	filed within 72 hours after Hygiene. ther than "natural", or Ite int, the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	O NOT use retired	ding mosi i)	t Of WORK	ng	0	<b>.</b>		
3 5	filed with Hygiene ther than	S	17. Father's Name ( <i>First</i> , <i>Middle</i> , <i>L</i> .	ast)		Clerk		19 Matha	r'a Nama	(First Middle	Ocean  Maiden Surname)	City	', Md.	
	ld be ental ked o	To Be	Joseph Holtma	,					bell					
$EQMQ_{C}$ Maryland 21215-0036	of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailing	Address (Street a			J	er, City or Town, St	ate, Zip	Code)	
	C = 0/ F		Mr. William Glad	ccum/ Nephew	<b>V</b>		Madonna			ie, Md.			ŕ	
Ocie.	Soft		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	B □Removal from State	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other place	e)	D	ate	20c. Location - Ci	ty or To	wn, State	
'~;	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Dula	ney Va	lley Mem	. 3	3-3-0	7	Timoniu	n, M	ld.	
MOC.	permit. Page Department of Important: If any Injury on	Į.	21. Signature of Funeral Service Li	755			Name and Addres Ruck To 1050 Yo	rk RO	L IO	wson. M	0. 212114		*	
$\succeq$			23a. Part1. Enter the dis Ase, or c shock, or heart failure. List of	omplications that caused nly one cause on each lin	I the death. ne.	Do not ente	the mode of dying	g, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Bet	e ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	As	pino	Hon r	oneu	AMOT	na			Onset and I	Death
	Examiner			Due to (or as	a conseque	ente of):								
5	10000000000000000000000000000000000000	Jer	Sequentially list conditions,	b. Out to for as	t conseque	singe off):	Jsp na	319				_		
RX	cate be execoted obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
200	be exec <b>r</b> ted ician and burial-transi	Ĕ	resulting in death) Last	Due to (or as	a conseque	ence of):								
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. , x	certifi ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	cv								
O. B.	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 4⊡Pregnant at 9⊡Unknown	2 Fetal of	death 3⊟E	Ectopic pregnancy Other <i>(specify)</i>				23d. Date o		-	Year
σ.	that the the seed by detac		Part II. Other significant condition	s contributing to death bu	ut not result	ing in the und	erlying cause give	n in Part I.		23e. Did tol	bacco use contribu	ite to the	e cause of d	eath?
rds	requires een sign	Completed by	Schizophrei	na						1 □ Ye			ably 4 🖼	
$O_{\text{cord}}$	law re as bee 2 sho	plete	,							24a. Was a		e autop	sy findings a	available
(X)=	The late had page	Nom								autops perforr 1 Yes 2	med? prio	r to com th?	ıpletion of ca 2∐ No	use of
Q.≅	ician: sertific sector,	Be	25. Was case referred to medical examiner?						of Death	(Check only on		103 2		
or C	Physi r this c ral dire	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur		R/Outpatient	3□ DOA Othe	4 LarNur			ence 6 DOther	Specify)	1	
OP	ttending death. stor; After the funer	tion	1 Natural 5 □ Pending	(Month, Day	Year)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? ′es 2∐N		8d. Describe ho	ow injury occurred			
Divisi	Atten r deat ector by the	fica	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be los Place of inte	ıry - At hom	e, farm, stree		- 2		Bf. Location (St	reet and Number o	r Rural	Route Numi	her
Ö	tal or is afte al Dir	Certification:	4   Homicide	building, etc	:. (Specity)					City or Town	n, State)	, , iarar	Troute Training	,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examination	edge, death on and/or inve	occurred at the time stigation, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, d	ause(s) and manne ate and place, and	er as sta due to	ted. the cause(s)	)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. License	number		25	9d. Date signed (A	fonth, D	ay, Year)	
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	6		30. Name and address of person wh	HAIN	e-2			1/2 _ 1		1 0	./11	,		
	Sta	е	31. Date filed (Month, Day, Year)	32. Registra	880 Ir's Signatu	re	alther	DOUL	evav	a, Po	irhville,	141	512 (	34
	Registra		MAR 0 2	2007	Wall Si	y for	edis				,			
DH	IMH 17 Rev 1/20	01	2.147.151.00	1										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2055 M 28 2007 Michael Patrick Flynn FF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes July 6, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1M 2□ F Maryland 67 213-36-4292 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han analysis as 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☑ No Director Maryland Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 3652 Cragsmoor Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Pharmacutical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel O'Brien John T. Flynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3652 Cragsmoor Court; Ellicott City, MD 21042 Wife Roberta Flynn 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 3/5/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Tuneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER LUNG **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-trar attending physician and Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4□Pregnant at time of death 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Illinknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an 1∐ Yes 2 100 Division or Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, DO0 63025 FEB -6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAMIR CHEEM A M.D., 5/24 10 OWLNGS CIRCLE MILLS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2 2007 Registrar

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			For	State of Ma	aryland / Dep					007	06404
		_	State Registrar		Ce	rtificate of	Death	2. Date of De	Reg. No.	.001	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Las Gilbert Fischb					Month 03	Day 01	2007	6:45 a <sup>M</sup>
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of			County of Death	
	Examin	er	Keswick Multic			Baltimo				,	
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th V Year	9. Birth	nplace (State or Foreign
	Director		093-10-8129	M 2□F	88 Yrs.	Months Days	Hours	Min. 5/20/1	918	New	
	p.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	shov shov	2	MD 10b. County		Baltimo						1 Yes 2 No
	the M	ect	10e. Street and Number		Daletino	10f. Zip Code			10g. Citi	zen of What Co	untry?
	with 3a or t be r		1103 West 37th	St.		21211		t	JSA		
	ms 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		lispanic Origi	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Amer Black, White	
٥	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 X Yes 2 ☐  If Yes, Give  Year or Dates:	No.	1 ☐ Yes 2 No	Specify:	r Bolto Filoarij Gioly		Specify. Whi	te
9500-61212	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	d by	3 Widowed 4 □ Divorced				ation			nd of Business/I	
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7	withir ene. than he M	ğ	Elementary/Secondary (0-12)	College (1-4or 5	Buv				Ret	ail	
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yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	10 B	Abraham Fischb					a Eisenbe			
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≥ ~`	and lealth m 27 her tr		Sylvia Fischba	cn-Brade	n µ103		ı St.	Baltimor		cation - City or	
Baltimore,	iges 1 nt of h if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐		cemetery, cre	ematory or other plac	1				
≣	it. Pa intmer intant: injury		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Lices		Chesapeak	22. Name and Addre	ss of Facility	-2-2007 Cremation +	E and	tsvili mal All	e, MD
g	Depa Impo any i		) Constitution of Mariotal Control and	>inc	1000			res Dr. To			
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	Physician		Immediate Cause (Final disease or condition	MATA	STATIL	colon c	Ance	R			Onset and Death
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	Examiner		Sequentially list conditions,	b							
/	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as	a consequence of):						
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760,	ate be executed hysician and the burial-transit	cal	(	d							
9	tificati ig phy as the										
X Q Q	death certificat e attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth	2 Fetai death 3	□Ectopic pregnanc	y		1	23d. Date of deli Month	very Day Year
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	t time of death 5	Other (specify)				WOITH	Day 10ai
<u>Р</u>	The law requires that the de ate has been signed by the s bage 2 should be detached		Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
Vital Records,	w requires that s been signed b should be deta	l by						10	Yes 2	□ No 3□ Pr	obably 4 Nnknown
Ö	v requ been shoul	Completed						24a. Was	an	24b. Were au	topsy findings available
Ř	sician: The law certificate has l irector, page 2 s	dwo							ormed?	pnor to death?	completion of cause of
ā		Be Co	25. Was case referred to medical				26. Place of	1  Yes of Death (Check only	21 No one)	1 1 1 1 6 3	200
	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 Z	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	ent 3 DDA Oth	ner: 4 Nurs	sing Home 5 ☐ Res	idence	6 □Other (Spec	cify)
Division or	ding Physician: n. After this certific funeral director,		27. Manner of Death  1 ★Natural 5 □ Pending	28a. Date of Inju (Month, Da		Wor		28d. Describe	how injur	y occurred	
SIO	Attendie er death. rector: A by the fu	catic	2 Accident investigatio 3 Suicide 6 Could not b		A harra farm a		Yes 2 □ N		(Chro oh o m	d Number of Br	und Davida Musebas
Š	or At fiter d Direct in by	Certification:	4 Homicide determined	Zoe. Flace of III	ury - At home, farm, s cc. (Specify)	treet, factory, office		City or To			ıral Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director,		29a. Certifier 1 Certifying Pl	nysician: To the best	of my knowledge, dea	ath occurred at the ti	me, date and	I place, and due to the	cause(s)	and manner as	stated.
	e Hos 124 h	edical	(Check only 2 Medical Exa	miner: On the basis of and manner st	of examination and/or ated.	investigation, in my	opinion, deat	h occurred at the time	, date and	d place, and due	to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier	>/		29c. Licens				te signed (Mont	1
			Hilam	y anno			3510	2	m	Arch	2007
•	ati		30. Name and address of person who	- 44	teath (Item 23a) (Type	e, Print)	Strist	· Balfin	OVE	MAVU	Ann
	Sta	to-	31. Date filed (Month, Day, Year)	0.	rar's Signature	V 1 1 5 1 1 1	V - C V		-1(	11111	
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death Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 le marked other than "naturel", or ite Baltimore, Maryland 21215-0036 permit. Pages 1 Department of P Importent: If ite any injury or ot once.

> Physician /Medical **Examiner**

·Ru Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria ned by the attent detached for u been signed t should be det filled in by the funeral director, page 2 To the Hospitel or Attending Physician: this After death. within 24 hours after deat To the Funerel Director:

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 26,200 1132AM February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death **Examiner** Good Samar PI Ta fan 05 Baltimor If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country)
Bathonere Mi 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2□F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show item 27 le marked other than "naturel", or Items 23e or 28e-f shov other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Race Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify. 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, MD 20174 Date 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 P
4 Donation 5 Other (Specify) 3 □Removal from State barrison Vaughn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Randa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. pproximate Interval Between Onset and Death Immediate Cause (Final newschentec yeurs resulting in death) ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \( \text{Yes} \) 2 \( \text{No} \) No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Onknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 1 Inpatient P 1 🗌 Yes 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March pleted cause of death (Item 23a) (Type, Print) 30. Name and address of MI) Boulevan. 5001 Loch 31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

		í	For State Registrar		State o	f Marylar		artment rtificate			and M		gien Reg. N		) 7	06406
	7		1. Decedent's Name (First, M.	ddle, Last)								2. Date of De Month	ath Di	av	Year	3. Time of Death
-	Physicia /Medic		Gloria A, Ga	yleard	1							Februa		-	2007	8:45 a M
7	Examin		4a. Facility Name (If not institu	tion, give str	reet and nu	mber)		4b. City, 7	Town, or	Location of	of Death			c. County	of Death	
-		Ť.	327 S. Calho	un Sti	reet				ltin						n/a	
	Funeral		5. Social Security Number	6. Sex	M 2 <b>3</b> F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year	-)	9. Birthp	lace (State or Foreign try)
*	Director		217-12-6646		IVI 2 2 1		82 Yrs.					3/3/2	24		New	York
	and *		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. Ci	ity, Town or Lo	cation					-		11	0d. Inside City Limits
	Aaryl sho	5	261				n - 1 -									1 X Yes 2 □ No
	28e-	Director	10e. Street and Number	n/a			ват	10f. Zip					10g. C	itizen of \	What Coun	try?
	with 3a or	۵	327 S. Calhou	n Str	eet				212	223				US	Α	
	ne 23	era	11. Marital Slatus		2. Was Dec	edent Ever in U	J.S. 13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)		14. Rac	e - Americ	
മ	or Item	Funeral	1 Never Married 2 N	larried	Armed Fo	2 No					i, Puerto	Hican, etc.)			ck, White,	etc.
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2	within 72 hours after death with the Maryland ene. than "netural", or iteme 23e or 28e-f show the Medical Exeminar must be natilied at	Completed	15. Dece (Specify only his	lent's Educa			(Give	dent's Usua kind of won	k doné d	luring mos	t of work	ng	16b.	Kind of B	usin <i>e</i> ss/Inc	fustry
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and	be fi	Be	17. Father's Name (First, Midd	ile, Last)											10)	
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Maryland 21215-0036	12 st h and 7 Is n treun		19a, Informant's Name/Relati			) l- +		_								
	1 and Healt em 2 ther		Gloria T. McI	augni	1n / 1	Daughte:	Place of Dispo	sition (Nam	e of	1		Date			City or To	
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Iteme 23a or 28e-1 show any injury or other treumatic event, its Medical Examinat must be notified at once.		21. Signature of Furieral Serv	ice Licensee								udon Pa Baltimo				
	3		23a. Part1 Enter the disease	or complica	ations that o	aused the dear								riai	yrano	Approximate
			shock, or heart failure. Immediate Cause (Final	ist only one	cause on e	each line.			-, .	,		,				Interval Between Onset and Death
A Company	Physician /Medical		disease or condition resulting in dealh)	a.		(or as a consect Alloro	ry opp	17174								
	Examiner				Due to	(or as a consec	quence of):	0.0								
		e.	Sequentially list conditions, if any, leading to immediate	b.		(or as a consec										
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	≺												
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Box	ndin use	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	230		tcome of pregn		7C-+i						23d. Da	te of delive	ry
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	or Attending Physicien: The law requires that the sifter death. Director: Atter this certificete has been signed by the in by the funeral director, page 2 should be detache.	by P	Part II. Other significant con-	litions contr	ributing to d	eath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use conl	ribute to th	e cause of death?
ğ	w require been sig should b	edit	Chra	un_	obstra	n forl	fre	DC				10	res 2	A NO	3 Prob	ably 4 □Unknown
Division of Vital Records,	aw re	Completed										24a. Was		24b.	Were autop	osy findings available inpletion of cause of
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ā	rtifice	0	25. Was case referred to med	ical						26. Place	of Deat	(Check only o		· 1.		
<b>&gt;</b>	nysic IIs ce direc	To B	examiner? 1 ☐ Yes 2 ☑ 🙌	Ho	spital:	Inpatient 2	ER/Outpatier	1 3 DO	A Othe	r: 4 □ Nu	rsing Ho	me 5 Resid	dence	6 Oth	er (Specify	)
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Ë	i or Attending Ph efter death. Director: After th I in by the funeral	Certification:		emined	28e. Place buildi	of Injury - At hing, etc. (Speci	io <b>me, far</b> m, str <i>fy)</i>	eet, factory,	office			28f. Location (S City or Tox			er or Rura	l Route Number,
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	To the Hospitei within 24 hours e To the Funerel I completely filled	Med	one) 29b. Signature and title of cer	afier	and man	ner stated.		29c	License	number			29d. Da	ate signe	d (Month, L	Day, Year)
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	5		30. Name and address of pers	on who com		or death (Iter	191/12 1A	/ RA	11.	י סבוז	Stre.	et BI	н ж	MA	7.17	7 3
7	Sta	te.	31. Date filed (Month, Day, Ye		3245	gistrar's Sign	ature _	· ///	i ji NV	//( -	,, ,	1)17/	0	,-, W	U1C	. ( )
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27, 2ď07 FEBRUARY ANNA GREENBLATT 1:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/01/1917 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 ▼ F Days Hours Min 89 216-30-8269 Director POLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Exa⊞iner must be notified at Director BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT #209 21117 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE Completed by 3 X Widowed 4 ☐ Divorced Specify: permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER **GROCERY STORE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YANKL MONCIARZ RIVKA (UNOBTAINABLE) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL PONCZAK / SON-IN-LAW 5904 GENTLE CALL - CLARKSVILLE, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 03/01/2007 4 Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Sign to re Funeral Service Lick nisee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yens /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 No detached the 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe Completed 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy page certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Whether (Specify) NOSPICE SID 140 2 1 TYes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending To the Hospman within 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h. Signature apo certifier 29c. License number Um

D58303
February 27 2007

who completed cause of death (Item 23a) (Type, Print)

J. Uthh us, un 6701 N. Churles S. P. Barthure un 2204

State

Registrar

31. Date filed (Month, Day, Year) MAR 02 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Year 0633 AM ROME /Medical 01 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE TIMORE NASHINGTON MED, CENTER GLEN ANNE ARUNDEL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND A. 5 OUNI 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to Ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 2+HGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ORES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 ☐Removal from State ROWNSVILL 5 ☐ Other (Specify) 21. Signatur of Funeral Service License fault. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or real failure. List only one cause on each line. Approximate Interval Between Onset and Death iate Cause (Final **Physician** DEMENTIA dis-se or condition resulting in death) 2HELMERS Syears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed INSUFFICIENCE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No or Vital Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 1 Natural completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAR 0

808 LANDMARK DR, STEIZS GLENBURNIE, MD 21061 AWIN S, MADARANG W 32 Registrar's Signature

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Barbara Year Hoot 3:54 4M Felo 2007 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hiversity Maryland Medical Center Bult More, Mr If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | OCC 23, 1946 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 212-46-5375 1 □ M 2 🖫 F 60 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Worcester Director 1 ☐ Yes 21 No Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be nonce. 33 Windswept Drive 21811 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify Specify:White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Management Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles G. Hill Sr. Mary Rosalie Cooper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Hoot /son 2202 Emory Road Reisterstown MD 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State Date N☐ Burial 2 ☐ Cremation 3 ☐Removal from State 3/5/07 4 □ Donation 5 □ Other (Specify) Baltimore MD 21. Signature of Fyrm Service 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Home of Essex 21221 23a. Part1. Enter the disease or compleations that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sertic shock 5 day /Medical Due to ras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the signed by the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Şq Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier, 29c, License number 29d. Date signed (Month, Day, Year) AU4176435W16683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gircle, Ellicott Melissa Ballar 7734 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 2 2007 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygic

			1 - State Registrar	or Marylan	•	ariment of F rtificate of			,	giene Reg. No:		0.61.10
Ü	Dhysisi	a.m	1. Decedent's Name (First, Middle, Last)					2	2. Date of Dea		1001	3: Time of Death
N.	Physici /Medio		Soon Hwa Han						ebruar	cy 2	4, 200	07 5:30A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and 4737 Leyden Way	number)		4b. City, Town, o	r Location o			4c.	County of Dea	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under	24 Hrs. 8	. Date of Birth	1	HOW 8	rthplace (State or Foreign ountry)
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
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	r 28a	Director	10e. Street and Number			10f. Zip Code			1	10g. Citi:	zen of What C	ountry?
	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	al D	4737 Leyden Way			2104	42			1	U.S.A.	
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Maryland 21215-0036	2 should by and Menta Is marked raumatic ev	오	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street				r, City o	r Town, State,	Zip Code)
	ss 1 and 2 of Health a item 27 is		K.J. Kim (Daughter)			Loganber		ane F	ulton,	Maı	ryland	20759
ore	Jes 1 of He If Item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	om State 20b. P	lace of Dispo emetery, crer	sition (Name of matory or other plac		Dat		20c. Lo	cation - City or	r Town, State
Baltimore,	t. Pag tment tant: ijury		4 □ Donation 5 □ Other (Specify)		estlaw			2-27-				ille, MD
Ra	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic erone.	l	21. Signature of Funeral Service Lidensee	~~~	27	Name and Addre Witzke Fu 5555 Twin	neral Knol	Home:	s, Inc	iumb	oia, MD	21045
			23a. Part1. Enter the isease, or complications the shock, or heart failure. List only one cause	at caused the death on each line.							-2-140	Approximate Interval Between
	Physician / /Medical	00 (0	Immediate Cause (Final disease or condition resulting in death)			ncer						Onset and Death
	Examiner		Due	to (or as a consequ	uence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequ	ence of):							
<b>D</b> .	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events c									
68/60,	tificate be executed g physician and as the burial-transit	a E	Due	to (or as a consequ	ience ot):							
2	ficate physis the	ledical	d									
XOR			23b. Was decedent pregnant	outcome pf pregna ve birth 2 □ Fetal		Ectopic pregnancy				2	3d. Date of de	livery
о С	e deat he att	Physician/N	1 Yes 2 No 4 P	regnant at time of denknown		Other (specify)	<b>'</b>				Month	Day Year
J.	hat the		9 ☐ Unknown  Part II. Other significant conditions contributing	o death but not resu	Ilting in the ur	nderlying cause give	en in Part I		23e Did to	hacco us	se contribute t	o the cause of death?
Hecords,	The law requires that the death cer are has been signed by the attendin rage 2 should be detached for use	Completed by	Herentitis'			·,g			1 🗆 Y			robably 4 □Unknown
<del>ပ</del> ္သ	aw rec s beer 2 shou	olete	3						24a. Was a	ın	24b. Were a	utopsy findings available
		mo							autops perfor 1∐ Yes	med?	prior to death? 1 ☐ Yes	completion of cause of 2⊠,No
VITal	siclan: The law certificate has t irector, page 2 s	Be (	25. Was case referred to medical examiner?			To:		of Death (C	Check only on			
0	Physi this cral dire	2		☐ Inpatient 2☐ In	ER/Outpatien		4 LI Nu		5 Reside		Other (Spe	ecify)
0	th. : Aftel	tion		Month, Day Year)	Injury	Worl	k? Yes 2∐1		a. Describe III	JW IIIJUTY	occurred	
UIVISION	r Atter	Certification:	3 Suicide 6 Could not be 28e. P	ace of injury - At ho uilding, etc. (Specify	me, farm, stre	eet, factory, office		28f	Location (St City or Town	reet and	d Number or R	ural Route Number,
5	ital or irs aft iral Di											
	To the Hospital or Attending Physician: To the Funeral Birector: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  Certifying Physician: To 2 Medical Examiner: On the and r	the best of my know se basis of examinat manner stated.	vledge, death ion and/or in	n occurred at the tir vestigation, in my o	ne, date an pinion, dea	nd place, and ath occurred	d due to the c at the time, c	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	J-+-	P	29c. License	e number	1-0-	2	9d. Date	e signed (Mon	th, Day, Year)
			() /w/		)		25	135	1	-c)	Dies	26,2007
	8		30. Name and address of person who completed of	- 300	THO	So te D	2117	Gle	Du	m.	nd?	1061
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 0 2 2007	. Registrar's Signat	ure	de	,	, ,			,	

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan	d / Depart		alth and M	lental Hygie	_	06412
			Decedent's Name (First, Middle, Last)	,				2. Date of Death	140/	3. Time of Death
	Physici	an			Johnso			Month	Day Year	111 10 11
0	/Medic		4a. Facility Name (If not institution, gives	street and number)		o. City, Town, or Lo	neation of Death	Feb "	Z1 Z007 4c. County of Deatl	
	Examir	ier	C . D	A	1	o. City, Town, or Lo	. \\\ a			
			5. Social Security Number 6. Sex		lost hidhday	Under 1 Year	f Under 24 Hrs.	9 Date of Birth		imore
	Funeral Director			M 2□F 89	Yrs. N		Hours Min.	8. Date of Birth (Month, Day, You	9. Birti Co.	hplace (State or Foreign untry)
	and *		10a. State 10b. County	10c. Cit	v. Town or Locat	ion				10d. Inside City Limits
	affer death with the Maryland or iteme 23s or 28e-f ehow	ក	200		0 1	. 111 %				1 PYes 2 □ No
	he h	ect	MD Balti	more		nsville 10f. Zip Code		10-	Civi	
	A A	Funeral Director	10e. Street and Number	L = 1				10g.	. Citizen of What Co	untry?
	234 ath	a	1502 Frederic				338		US	
		Tue		12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	Decedent of Hisp es, specify Cuban,	anic Origin? (Spe Mexican, Puerto i	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	or i	Y F	1 Never Married 2 Married	1 Nes 2 No Are	7	Yes 2 No	Specify:		Specify:	
8	hours after turel', or ite	q p	3 Widowed 4 Divorced	Year or Dates:					131	ack
) 「	net right	Completed by	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give kin	s Usual Occupation of work done dur	on ring most of worki	ng 16I	b. Kind of Business/l	industry
7 2	within 72 ene. then 'ne	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired)			TI	
8 01	filed v Hygie ther t	ပိ	19 th		100		river	(27)	Truck	ing
2 E	be fill H d otl	Be	17. Father's Name (First, Middle, Last)	ONE		18	MAILE ME	(First, Middle, Mai	den Sumame)	
X a	should ind Men imarke umatic	2					Agnes	/ h	lilliams	
a	2 sho and 1s m		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing A	ddress (Street and	d Number or Rura	Route Number, C	ity or Town, State, Z	lip Code)
~ ≥	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 is marked other then "neturel;", other traumatic event, the Medical Exa		Dorothy Johns	son	5721	Edmonds		Corto	msville. I	MD alaa8
MAS OM Baltimore,	S 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		20a. Method of Disposition		Place of Disposition			ate 200	. Location - City or	
JO DE	Peges nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Modera		March	7000 G	1 1/2	CIN
1115 Baltimo	nit. Per pertmen cortant: injury		21. Signature of Funeral Service Licens	(e)	22. N	ame and Address		3, 200 1	Allo, 1	10
Ba	permit. Peges Depertment of I Important: if it eny injury or o				11 1	4.6	00 7 79 00	1. 1	7	Phones
9	_		23a Part Four the disease or compli	ications that caused the deat	Do not enter t	M/1939		May Dr.		Approximate
7			23a. Part1. Soler to disease, or compli shock, or heart failure. List only or	ne cause on each line.	II. DO NOT SEITSI I	le mode of dying,	sucii as cardiac o	res matory arrest.	-	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Parl	inson	s Dise	9se		i i	011001 4110 50411
-	/Medical		resulting in death)	Due to (or as a conseq						
	Examiner		Sequentially list conditions	0						
	D ==	Examiner	Sequentially list conditions, any, leading to minimal actions across. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	transe of):					
	be executed ician and burial-transit	Ē	Cause (Disease or injury that initiated events	2.						
ó	exe a∩ a∩ rial-t		resulting in death) Last	Due to (or as a consequence	uence of):					
760,	sicia ysicia e bu	cai		1						
68	ficat ph)									
Box	eath certificate be exattending physician for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna	incy				23d. Date of deli	VPD/
ă	atter for u	ciar	in the past 12 months?	1 Live birth 2 ☐ Fete 4 ☐ Pregnant at time of de		topic pregnancy her (specify)			Month	Day Year
Ö	by the de	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	02.11	nor (specify)				
P.O.	Physicien: The law requires thet the death certifica this certificate hes been signed by the attending phyral director, page 2 should be detached for use as the	윤	Part II. Other significant conditions con	atobuting to death but not res	ulting in the unde	rhing cause given	in Part f	23e Did tohac	co use contribute to	the cause of death?
Division of Vital Records,	w requires to been signer should be	þ		the standard of the teacher	aning with the dilde	nying cause given	will care is			obably 4 Dunknown
or o	neen	ted						1 165	2010 3071	Dodoly 4 Pacificiowii
ပ္မ	e law hes b	pie						24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
æ	r: The icete he	Completed						performed	death?	2□ No
ā	icien: certifice rector, p	(a)	25. Was case referred to medical	- P4		2	6. Place of Death	/Check only one	140	
>	ysicien: is certific director,	ToB	examiner?	lospital:	ER/Outpatient	3 DOA Other:	_		e 6 □Other (Spec	ii6.)
5	Phys er this eral di		27. Manney of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		28d. Describe how i		1197
S C	After Deling	Ė	t ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		s 2 □No			
<u></u>	dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome farm street	factory office		28f Location (Stree	t and Number or Ru	ral Route Number
Š	effer Dire	Certification:	4 Homicide determined	building, etc. (Specify	y)	laciory, cinco		City or Town, S	tate)	Tar Product Namoon,
_	pita ours orei		29a. Certifier 1 Certifying Phys	states. To this boas of our boar	and the second second		220000000000000000000000000000000000000	and the second		27202
	Hos 24 ho Fun fely	lica	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina	tion and/or invest	igation, in my opin	ion, death occurre	ed at the time, date	and place, and due	stated. to the cause(s)
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th cumpletely filled in by the funeral	Medicai	une)	and manner stated.						
	Twit of the state	-	29b. Signature and title of certifier	D 0 -4 .		29c. License n	-	I	Date signed (Month	
	\		Marin J.	Fulrit, MID		1000	58676	M	arch 1, 2	Loo t
2	1		30. Name and address of person who co							_
4	L		Karen L. Ball	itt, N.D. 2	TMa	1 street	14110	200 Rei	stors-w	, MI 2113
	Sta	ite	31. Date filed (Month, Day, Year)	32. Degistrar's Signa	iture		1			
	Registr	ar	<b>越</b> 在京 0 2 20	07	4 Ann	89				

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Ma	arylan		artment of H rtificate of		Mental Hy	gien Reg. N	0000	061.19
			Decedent's Name (First, Middle)	e, Last)					2. Date of D	eath	1-1/1/1	3. Time of Death
	/sicia ledic:		Ruth			Kr	etchmar		Februa	ry 2	25, 2007	4:20 A M
Exa	amine	er	4a. Facility Name (If not institution	, give street and number)				or Location of Deat	th	40	c. County of Deatl	n
			Casey House  5. Social Security Number	6. Sex 7. Aq	e (In vrs I	ast birthday)	Rockvil If Under 1 Year		8. Date of Bi		Montgome	
Fune Direc	_		566-70-5666	1□M 2\ F	96	Yrs.	Months Days	Hours Min.		av Year	) Co	nplace (State or Foreign untry) Jersey
and		-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Maryl -f sho	led a	ğ	Maryland Monts	omery	Roc	kville						1 ☐ Yes 2 🖾 No
n the	nocu	Directo	10e. Street and Number	,omery	ROC	KVIIIC	10f. Zip Code			10g. Ci	itizen of What Cor	untry?
th wit	ag 1sr	a D	6111 Montrose F	Road Apt. #8	302		2085	2		U	.S.A.	
er dea	er m	Funeral	11. Marital Status	12. Was Decedent Armed Forces? ed 1 Tyes 2 2 1	Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer Black, White	
Dallillore, Infallylating Z.1.2.13-00.30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examil	2	1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced	ied 1 ∏ Yes 2 🔼 I If Yes, Give Year or Dates:	No		1⊡Yes 2 <mark>⊠</mark> No	Specify:			Consitu	ite
72 hc 72 hc 1	alcai	eted	15. Deceden (Specify only higher	's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. F	Kind of Business/I	ndustry
within she.	No IMe	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retire nemaker	d) _		0	17	
filed Hygi	m, me		17. Father's Name (First, Middle,	Last)		поп	lemaker	18. Mother's Na	me (First, Middle	_	Home	
Id be fill fental H	a constant	To Be	Abraham Kemper					Rose M			_	
ary and N	an l		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	ber, City	or Town, State, Z	ip Code)
and and and m 27	Jet III		Paul Kretchmar	/Son	,		Ewing Dr			208	17	
Gest it of H			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation				sition (Name of matory or other pla		Date	20c. L	ocation - City or 1	own, State
Dallillor Dermit. Pages Department of mportant: If it	uland	-	4 □ Domation 5 □ Other (S		Bet		el Cemet		8/07	Woo	odbridge	, NJ
Department Department	once		Signature of uneral service	Fell		H	liggins a 82 Sprin	nd Bonne	r Funera	al Ho	omes	07000
3		$\dashv$	23a. Part1. Enter the disease, or	complications that caused	the death	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	arrest,	eld, NJ	Approximate Interval Between
Physici	ian		shock, or heart failure. List Immediate Cause (Final disease or condition	Dementi								Onset and Death
/Medi			resulting in death)	Due to (or as		ence of):						·
Examir		_	Sequentially list conditions,	b. —								
ted t	100	une	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):						
execunand nand	מו	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
icate be exphysician a		edical		<b>L</b> d								
ortifica ng ph	as a	Ş -	IF FEMALE:									
ath cer	i i	sician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	death 3	Ectopic pregnancy	у			23d. Date of deliver Month	ery Day Year
the de	nal i	ysic	1 □ Yes 2 🖺 No 9 □ Unknown	4⊡Pregnant at 9⊡Unknown	time of de	eath 5L	Other (specify) _				WORT	Day Teal
that set by led by	a dela	y Phy	Part II. Other significant condition	ns contributing to death be	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?
w requires to been signer of the signer of t		ag pa							10	Yes 2	M∑No 3 ☐ Pro	bably 4 □Unknown
law re	2 3/10	plet							24a. Was		24b. Were aut	opsy findings available
The The	hage	Completed							auto perfo 1∐ Yes	psy ormed? 2 No	death?	ompletion of cause of 2 ☐ No
VILCA ician: Sertific		ge	25. Was case referred to medical examiner?	Hoopital			Tou		ath (Check only			
Phys 2	<u> </u>	<u> </u>	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatien 28b. Time of		4 Li Nursing F	1			Hospice
ding .: After		TION	1 Natural 5 Pending 2 Accident investig	(Month, Day		Injury	Wor	yai k? Yes 2∐No	28d. Describe	now inju	ry occurred	
Atter ar deal	in h	110	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place of inju	ury - At hor	ne, farm, str	eet, factory, office		28f. Location (	Street ar	nd Number or Rur	al Route Number,
talor rs after al Dir		Certification:	4   Hornicide	building, etc	з. (эреспу,	,			City or To	wn, State	9)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in but the funeral director, and 2 should be detached for use on the build transit	in ferons in	Medical	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	f examinati	vledge, death ion and/or in	n occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s date an	and manner as d d place, and due	stated. to the cause(s)
within 5	3	ĭ ĕ	29b. Signature and title of certifier	Time			29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
			Kynthia?	n Dill	Los.	mo Do	) HOO	58032		2	2-26-	-2007
6			30. Name and address of person Cynthia M. Wil							/ille	e, MD 208	355
	Stat	е	31 Date filed (Month Day Year)									
Reg	gistra	r	MAR 0 2	2007 32. Registra	1 15	100						
DHMH 17 Re	v 1/200	)1				-10						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 7:00 PM renned ancis 2007 /Medical ידפטול. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Centar Baltimore Baltimore 1 red. cal MIETCH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X**M 2□ F Yrs. **Director** 6/19/22 44 Montana <u>558-35-1460</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Baltimore Md n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA Funeral 2905 Shirey Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Patrick Kennedy Elizabeth Kennedy ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Alamo, California 94507 Mr. Bill Kennedy / Brother 105 Garydale Court 20b. Place of Disposition (Name of Bate 1910) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 2/28/07 Baltimore, Maryland 22 Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pancreatit, dau /Medical ue to (or as a consequence of): Examiner Cohol abuse Sequentially list conditions, if any, leading to immediate stude. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes ➤ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No autopsy performed? this certificate 2☐No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes > No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director; A death. 1 ☐ Yes 2 ☐ No thef 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21182 0 Medical 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul 3 301 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 27, 200 **Physician** 9:19AM FEBRUARY OROTHEA CLAUSMEIER /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ASSISTED LIVING DERRY HALL BALTIMORE MA MAISON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birth place (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗙 F 93 218~01~1257 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2XXNo Perry Hall- Baltimore County Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "neturel", or Iteme 23a or 21236 USA 3920 Klausmier Rd. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes X No Specify: ۾ 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Housewife Housekeeping-Own Home 12th grade or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if tiem 27 is marked oth any liqury or other treumatic event ones. Be ၀ Gustav M. Biedermann Bertha W. Buehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Walter Ave. Baltimore, Md. 21236 John F. Klausmeier (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's L.C.C. 3-3-2007 4 □ Donation 5 □ Other (Specify) Baltimore, Md. E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 21. Signature of Fundamenyice Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VEMENTIA STAGE **Physician** [ND] EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown To the Hospital or Avenance, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to the Funeral Director. After this defined or by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Anatural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year) 17041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #38 LUTHERVILLE MARC I. LEAVEY MY Negistrar's Signature 31. Date filed (Month, Day, Year) State MAR 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:30AM 02 LLIAM 27 MILTON 2007 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore

Hinder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Min Wilson, NC Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notifled at 1 Yes 2 □ No Director more - 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) the *l*vation Manager traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ACU P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau Plainfield Ave Baltimore, MO 21206 MUDI Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 □Removal from State MD National Cen. 4 Donation 5 Dother (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licenter M01401 8728 LIGIN ao 23a. Part 1. Fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for Month Day in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 4 Unknown 2 No 3 Probably 1 ☐ Yes cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify)
Injury\_at 28d. Describe how injury occurred Hospital: Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient Manner of Death

Natural

Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title cause of death (Item 23a) (Ty LOCH RAVEN BLUD BALTIMORE A 51 H. 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 28, **Physician** 2007 9:20 A.M Audrey F. Lemmon February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stell Maris Baltimore Towson 8. Date of Birth (Month Day Year) 9. Birthplace (Star March 26,1926 Mary Land If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Hours Days Months 1 □ M 2 🖫 F 80 220-12-7679 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐Yes 2 XNo Howard Columbia Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7020 Cradlerock Way #416 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No Specify: Specify: 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Technician Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph L. Spilker Laura Gingrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6902 Sherwood Road; Baltimore, Maryland 21239 Sharon Lee Von Paris Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 3/6/2007 Woodlawn, Maryland 21. Signature of Funeral Sovide I censee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catons Ville, Inc. 23a. Part. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only one cause on each line.

Immediate Cause, inal disease or condition resulting in death)

a. CHRONIC OBSTRICTIVE 1630 Edmondsno Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecuence of Examiner burial-tra Due to (or as a consequence of) physician s the burial Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1□ Yes 2**X** No Physician: 25. Was case referred to medica examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident Director: filled in by the 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		-	For State Registrar	State of Mary		artment of Hortificate of E			iene <sub>eg. No</sub> 2007	06419
			1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	h Day Year	3. Time of Death
	Physicia /Medic		Γ	ESMOND D.	LY(	ЙC		FEB. 2		10:04 A <sup>M</sup>
,	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
			CARROLL LUTHERA				INSTER		CARROLL	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8 / 25 / 1	Year) 9. Birth	nplace (State or Foreign untry)
	Director	}	510-16-4692   Land Residence of Decedent		0.5			0/23/1	921 KANS	SAS
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Man a-f sh	tor	MD CARROLL		WESTMIN	STER				1 X Yes 2 ☐ No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a	ral	225 FROCK DR.	·			1157		USA	
	ar dez	Funeral	11. Wallar States	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ሺ Widowed 4 ☐ Divorced	12∏Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: WH	ITE
8	within 72 hours after death with the Maryland ene. then "netural", or iteme 23a or 28a-f show the Madical Examinar must be notified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ition		16b. Kind of Business/l	
72	n "ne	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	furing most of work. )	ing		
21	giene grethe	Completed	8			CARPI	ENTER		CONSTRUC	CTION
ם	be filed stal Hygid od other event, t	Be (	17. Father's Name (First, Middle, Last)	~ ~ ~ ~ ~	****		18. Mother's Name			
<del>Z</del> a	should I and Meni marke umatic	ျာ			YON	4 (0	FEI		EPTER ; City or Town, State, Z	in Code)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelih and Mental Hygiene. If Heelih and Mental Hygiene them 23 is marked other then "netural", or iteme 23a or 28a-f show then traumatic event, Ira Madical Examinar must be notified at		19a. Informant's Name/Relationship (Ty) JOANN WISNER -	- DAUGHTE		BOX 77,				344
ė,	permit. Peges 1 and Department of Heelt importent: If Item 2 eny injury or other once.		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of			20c. Location - City or	Town, State
Baltimore,	ant of tr: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		matory or other place		26/07 5	SYKESVILLI	E. MD
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ä	Depa impo eny ii		N YHX		2	254 E. M	AIN ST.	,WESTMI	NSTER, MI	21157
			23a. Part I. Enter the disease, or complishock, or lead failure. List only or	cations that caused the	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End	Stew	COMM	1- En	eles.		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		(	0000		9
	LXdiffile	_	Sequentially list conditions,	Due to (or as a co	Menus of):	ai				30
	ted nslt	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (01 43 4 00						$\bigcirc$
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	the death cartificate be executed y the attending physicien and iched for use as the burial-transit	dical		J						
9	ng ph as th	Medi	IF FEMALE:							
Box	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
o.	at the dea by the at itached fo	Physician/Me	1 Yes 2 No	4□Pregnant at tim 9□ Unknown	e of death 5 (	Other (specify)				•
<u>α</u>	that thed the		Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the (	anderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	S C 9	d by						1 🗆 Y	es 22 No 3□Pr	obably 4 Unknown
co	w requir been si should I	Completed						24a. Was a	ın 24b. Were au	topsy findings available
Re	The lav	E						autops perfor	med? death?	completion of cause of
ital	₩ ∞-	0	25. Was case referred to medical				26. Place of Deat			
<u></u>	Physician: this certific ral director,	To B	examiner?	lospital: 1 Inpatient	2 ER/Outpatie		402 INUISING FIC	ome 5 Resid	ence 6 □Other (Spe	cify)
n of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time ( ear) Injury	Work		28d. Describe h	ow injury occurred	
sio	Peat or.	catl	2 Accident investigation 3 Suicide 6 Could not be	- Bi (11)	A) b		Yes 2 □No	29L Location (C	treet and Number or Ru	eral Pauta Number
Division	ਤੇ ਵੇਂ ਵੇਂ ⊆	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	- At nome, rarm, si Specify)	reet, factory, office		City or Tow	n, State)	irai noble ivaliber,
	spital		29a. Certifier 1 Certifying Phy	sician: To the best of n	ny knowledge, dea	m ocurred at the tin	ne, date and place,	and due to the c	ause(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral Completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of ex and manner states	amination and/of i	estigation, in my of	pinion, death occur	red at the time, o	late and place, and due	to the cause(s)
	To the Hospital within 24 hours e To the Funerel Completely filled	Me	29b. Signature and title of certifler	//	11	29c. License	e number	2	29d. Date signed (Mont	
	. 0			2/2		13-	1949		teh-26th	7005
	14.		30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Tybe	, Print)		C 1_	as a M	12007 M. 26157 AMINISTIN
			31. Date filed (Month, Day, Year)	Penistrar's	Signature	There	1 hone	Dule	- cel wer	wide many
	St Regist	ate rar	MAR 0 2 2007	Market S	1	A CONTRACTOR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month SR **Physician** 3 NPM Chrisy 200 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore City MURSING SAMARITAN CTA MORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Min. May 6 1913) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 € M 2 □ F 93 214 01 3106 Trinidad, Colorado Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show r than "natural" or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2913 Scherer Avenue USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Maryland 21215-0036 White þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Machinist Martin Marietta Ith and Mental Hygic 27 Is marked other raumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angelo Liberto Mary Sessano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If item 27 Is eny injury or other trau Robert A Liberto 5004 Forge Haven Drive Baltimore, Maryland 21128 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. March 2 2007 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Figurature of Funeral Service Licentee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician ar P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No Completed RILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH KAVE. HAE 560 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

**Physician** /Medical **Examiner** Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exeminer must be notifiled at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burial-transit ormpletely filled in by the furneral director, page 2 should be detached for use as the burial-transit

Certification: 3 ☐ Suicide 4 Homicide 29a. Certifier Medical (Check only one

6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of per-

Geys Road Bultimori, MD 21228 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

700 Dorian MAR 0 2 2007

	ecol		For State Registrar		Marylan	_	artment of rtificate of			R	eg. No.	7	06422
	Physicia	212	Decedent's Name (First, Middle	, Last)						<ol><li>Date of Dear Month</li></ol>	th Day	Year	3. Time of Death
	/Medic	al	Larry	Jame		N	Miller,			Februar		2007	6:00a <sup>™</sup>
13	Examin	er	4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town,		of Death		4c. County		
			1222 Elmridge	Ave.		1 11 11 11 1	Balti If Under 1 Yea		r 24 Hrs.	O Date of Diet		imore	ace (State or Foreign
В	Funeral		5. Social Security Number	6. Sex 1 <b>⊠</b> M 2 ☐ F	7. Age (In yrs.	V	Months Day		Min.	8. Date of Birth (Month, Day 1/13/4	Year)	Count Mary	ace (State of Poreign
É	Director		214-40-0197 Usual Residence of Decedent		64					1/13/4	3	ilal y l	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
	Mary feb	jo	MD Balti	more		Ва	ltimore						1 ☐ Yes 2. TNo
	r 28a	Director	10e. Street and Number	more			10f. Zip Code			1	0g. Citizen of W	/hat Count	try?
	3a o	0	1222 Elmridge	Ave.				21229			US	A	
	deat	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.	Was Decedent of	f Hispanic Or Joan, Mexica	rigin? (Spec	cify Yes or No-	14. Race Blac	- America k, White, e	
9	after or Ita		1 ☐ Never Married 2 Marri	ed 1 Yes	2 🗌 No		1 ☐ Yes 2 1 N			,		Whi	1
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show aimportant: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show aimportant: if item 25a or 28a-f show aimportant or 25a or 28a-f show aimportant or 25a o	d by	3 Widowed 4 Divorced	Year or Da	tes:Vietn	am							
5	72 h	Completed	15. Decedent (Specify only highes	's Education it grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during mos	st of workin	ng .	16b. Kind of Bu	siness/Ind	lustry
121	within ne.	d E	Elementary/Secondary (0·12)	College (1	4or 5+)		Cruck Dr					Frei	ght
2	lled v dygie ther t		17. Father's Name (First, Middle,				Tuck br		er's Name	(First, Middle,	Maiden Sumam		
and	ntal h	Be											
Maryland	d Me	2	Nolan Franklin  19a. Informant's Name/Relationsl			19b. Maili	ng Address (Stre			le Smith Route Numbe		State, Zip	Code)
<u>≅</u>	d 2 s th an t7 is		Mrs. Shirley G.		Wife	1	Elmridg						
a,	1 an Heal em 2		20a. Method of Disposition	militer /	20b. F	Place of Dispo	osition (Name of			ate	20c. Location -		
Baltimore,	ages int of t: # it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		state	•	matory or other p	1	2/2/	07 T	. 1	М	1 1
턡	iit. Partme		21. Signature of Funeral Service		Lou	don Pa	rk Cemet	ress of Facil	lity Lou	don Par	Baltimor k Funer	e, Ma al Ho	aryland ome
Ba	Depa impo any i		1				620 Will						
			23a. Pan 1. Enter the disease, or	complications that ca	used the deat	h. Do not en	ter the mode of d	lying, such as	s cardiac or	r respiratory are	est,		Approximate Interval Between
760,	Physician /Medical Examiner parish and prisel-transit prisel-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (	or as a consequence or a consequence or a	uence of):	CARDI	/AL	Zore,	FARC	TION		Onset and Death
687	a × a			d									
P.O. Box 6	Physician: The law requires that the death certificat t this certificate has been signed by the attending phy rai director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	□Ectopic pregnal □ Other (specify)				23d. Dat Mor	e of delive nth	⊓y Day Year
	that ned b		Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the c	underlying cause	given in Part	1.	23e. Did to	bacco use conti	ribute to th	e cause of death?
sp.	uires n sign lid be	d by	Samoul	Cell C	new	Fes.	Form	5-	ruce	_ 1□Y	es 2□No	3 Prob	ably 4 Unknown
Records,	w requir been si should	Completed	5.							24a. Was		Vere autor	osy findings available
Re	The lav	Ĕ	- men-c							autop	med?	leath?	mpletion of cause of
Vital	ian: The rtificate	CO	25. Was case referred to medica					26 Plac	re of Death	1 ☐ Yes		Yes	2 140
Ξ	sicia cert lirect	O B	examiner?	Hospital:	npatient 2	TER/Outpatie	nt 3 DOA	Other			ence 6 Oth	er (Specifi	()
of	Phys sr this srai di	H	27. Manner of Death		of Injury h, Day Year)	28b. Time o		njury at Vork?			ow injury occurr		<del>'</del>
lon	nding Ith. : After e funer	ig ig	1 □ Natural 5 □ Pendir 2 □ Accident investi	'9	n, Day 19ar)	Injury		Yes 2	□No				
Division	il or Attending after death. Director: After d in by the fune	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 200. Flace	of Injury - At h ng, etc. (Speci	ome, farm, si	treet, factory, office	сө	2	28f. Location (S City or Tow		er or Rura	l Route Number,
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by	edical C		ng Physician: To the Examiner: On the b and man									
	o the	Me	29b. Signature and title of certifie				29c. Lice	ense number	7		29d. Date signed	d (Month,	Day, Year)
	- > - O		-	2	MO		1	7555	100		02/	27	2/2007
	111		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type	, Print)		0		-		
	1511		Est Fren	190 -	3720	1 /	ofce s	Treel	6	Hom	e/6.	-	1/2/225
	s St	ate	31. Date filed (Month, Day, Year,	3 <b>9</b> . F	egistrar's Sign	ature	and a			-	-		0ay, Year) 2/2007
18	Regist		MAR Q 2	2007	Esser A	1							

			For State Registrar	State of M	Marylan	•	artment of F			-	giene Reg. Nd.	07	06423
	Physici		1. Decedent's Name (First, Middle, La	st) A		ME	ONGF		-0	2. Date of Dea		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv		,		4b. City, Town, o		n of Death	, ,,		nty of Deat	th
-			Howard County G 5. Social Security Number 6. S			L last birthday)	Colum		er 24 Hrs.	8 Date of Birt		ward	thplace (State or Foreign
В	Funeral Director			<b>™</b> 2□F	92		Months Days	Hours	Min.	8. Date of Birt (Month, Day Dec. 2	4,1914	Pen	insylvania
200	pu »		Usual Residence of Decedent  10a, State 10b, County		10c City	y, Town or Lo	cation						10d. Inside City Limits
	Maryla f shov led at	ō	Maryland Howard		100.00	Colu							1 ☐ Yes 2 🛂 No
	r 28a-	Director	10e. Street and Number			0010	10f. Zip Code				10g. Citizen o	of What Co	ountry?
	th with	al D	10735 Bridlerein	Terrace			210	)44			U.S.	Α.	
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of I f Yes, specify Cub	dispanic ( an, Mexic	Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)	14. <b>R</b>	lace - Ame lack, White	rican Indian, e, etc.
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □XYes 2 [ If Yes, Give Year or Date:			I∐Yes 2∏XNo	Speci	fy:		Spec	cify:	White
21215-0036	2 hou natura Ical E	ted	15. Decedent's E	Jucation			dent's Usual Occup		upot of working		16b. Kind of		
218	ithin 7 ne. nan "r	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. I	OO NOT use retire	d)			Automo	obile	
72	Hygier Hygier ther th		17. Father's Name (First, Middle, Last	)		Finan	ce & Insi	_		ager   (First, Middle,			
Maryland	ental l ked oi ic eve	To Be	Antonio Mongell					10.1110		DeMuco		umo)	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (			19b. Mailir	g Address (Street	and Nun	nber or Rura	l Route Numbe	er, City or Tow	vn, State, 2	Zip Code)
∑,	and 2 ealth a m 27 I		James A. Mongell	o (Son)			5 Bridle	rein			umbia,		
lore	iges 1 nt of H If iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		te C	emetery, crer	sition (Name of natory or other pla	,		ate	20c. Location	-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lie		Ga		Heaven Co		3-2-				ing, MD
Ba	Dep Imp		MXCH	tekmi			Name and Addrewitzke Fi 5555 Twir	inera 1 Kno	al Hom Dis R	es, Inco	lumbia	, MD	21045
3			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	sed the deatl	and the same of th			as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>SE</u>	7110		ottoci	4					Onset and Beauti
	Examiner			ABO	as a consequ	WAL	SEPS	15					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for	as a conseq		De De	14 (2)	>				
5-	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):	191 M	IT T					
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical E		d R	ENK	e.	FUL	UR	ک				
9	rtificate ng phys as the	/ledi	ic cerus e.										X.
Box	death certific attending p	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1☐Live birth	n 2 □ Feta	death 3	Ectopic pregnanc	y				Date of deli Month	ivery Day Year
o.	the de y the a iched t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknowr		eath 5L	Other (specify) _						
S,	w requires that the d been signed by the should be detached	by Pt	Part II. Other significant conditions	contributing to death	but not resi	ulting in the u	nderlying cause gi	ven in Pa	rt I.	23e. Did to	bacco use co	ontribute to	the cause of death?
ord	require sen siç iould b	ted t								101	∕es 2 No	3 □ Pr	obably 4 Miknown
or Vital Records,	e la has	Completed								24a. Was autop		b. Were au prior to d death?	topsy findings available completion of cause of
la F	ician: The certificate ha ector, page		25. Was case referred to medical					00 81		1□ Yes	2 10 No	1 ☐ Yes	2 <b>P</b> No
Ž	S	To Be	examiner?	Hospital: 1 Inpe	atient 2	ER/Outpatier	t 3 DOA Oth	nor:		<i>(Check only o</i> ne 5 ☐ Resid		Other (Spe	cify)
n o			27. Man or of Death 1 UNatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	Wo			8d. Describe h			
Division	Attending r death. ector: After oy the fune	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		iniury - At ho	ome farm str	M 1 ===================================	Yes 2		Of Logation /	Street and Nur	mhar or Br	ural Route Number,
<u>≥</u>	al or A s after il Dire	Certification:	4 Homicide determined	building,	etc. (Specif	y)	osi, raciory, omoc			City or Ton	n, State)	mber of the	mai rioute Number,
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical (	29a. Certifier (Check only one)	nysician: To the be miner: On the basis and manner	s of examina	wledge, deat tion and/or in	n occurred at the t vestigation, in my	ime, date opinion, d	and place, a death occurr	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	s stated. to the cause(s)
	To the I within 2.	Ž	29b. Signature and title of certifler	lale of	NS		29c. Licens	se numbe	787	1	29d. Date sign	ned (Monti	h, Day, Year)
	641		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print) KEN BAC	JN E	HIS	SET	io.	212	01.
	Sta Registi		31. Date filed (Month, Day, Year)		strar's Signa	ature	. A						
	IMU 17 Boy 1/2		MAR 0 2 20	U ( STATE OF ALL	an for	- ANDAS	No.		<del></del>				

ORIGINAL

			State of Maryland / Depa		Mental Hygie	ene			
			1. Decedent's Name (First, Middle, Last)	tificate of Death					
	Physici		Dr. Charles Patterson McCausland, Jr.	. D.D.S.	2. Date of Death Month February	Day 28, 2007 11:30 A M			
N. W.	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
	*		3611 Worthington Avenue	G1 yndon		Baltimore			
	Funeral Director		5. Social Security Number 213-38-7768 6. Sex 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Sept. 17,	9. Birthplace (State or Foreign Country) Pennsylvania			
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	eation		10d. Inside City Limits			
	daryla f sho	or	MD Baltimore Glyndon			1 ☐ Yes 2 ☑ No			
	the N	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?			
	h with	al D	3611 Worthington Avenue	21071	U	SA			
	ems sermo	Funeral		Vas Decedent of Hispanic Origin? (Sp 'Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.			
36	rs after i, or it xamine	by Fu	1 Never Married 2 Married 1 X Yes 2 No	☐ Yes 2 🗖 No Specify:		Specify: White			
Š	2 hou natura Ical E	ted	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16	b. Kind of Business/Industry			
218	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (U-12)   College (1-4or 5+)	kind of work done during most of work OO NOT use retired)					
2	lled w Hygier her th		12 5+ Dentis		De (First, Middle, Ma	entistry			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Charles Patterson McCausland	Aileen H		den Sumame)			
ary	shou and M s mar		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	g Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip Code)			
% ∑	and 2 lealth m 27 I	XX		Northington Avenu					
or E	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State  20b. Place of Disposicemetery, crem.	1		c. Location - City or Town, State			
	artmel artmel ortant Injury			ervice Corp. 3/2/ Name and Address of Facility		owson, MD			
ä	permit. Departr Importa any Inji		1/844/1/11	k Towson Funeral		LO50 York Road Towson, MD 21204			
	e 9. 5	Į.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only only cause on each line.						
	Physician		Immediate Cause (Final disease or condition	- / /		Onset and Death			
	/Medical Examiner		Due to (or as a consequence f):						
		e	Sequentially list conditions D.	enosis		10 heav?			
	cuted nd ransit	Examiner	if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
8760,	cate be executed ohysician and the burial-transit		resulting in death) Last						
289	ficate physi s the b	edical	d						
X Q Q	death certifica e attending ph d for use as th	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death 3 □ E	Catagiagram		23d. Date of delivery			
о С	0 0 0	sicie		Ectopic pregnancy Other (specify)		Month Day Year			
٦.	res that th signed by be detacl		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?			
Vital Hecords,	The law requires that the te has been signed by the age 2 should be detache	ed by			1 □ Yes	2 <b>M</b> No 3 Probably 4 Unknown			
ဝ၁	law re as bee 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
<u> </u>		Com			performe 1 Yes 2 ☑	d?   death?			
<u> </u>	ician certifi ector	B	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	th (Check only one)				
ō	Phys r this ral dir	Ę.	1 ☐ Yes 2 No Prospitation 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5K Residence 28d. Describe how	e 6 Other (Specify)			
<u>o</u>	nding tth. r: Afte e fune	ation	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work?  M 1 Tyes 2 No		.,,,			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)			
	pital o		29a. Certifier 1ECertifying Physician: To the best of my knowledge, death	annured at the time, date and place	and due to the sour	o(s) and manage as stated			
	n 24 hc	edica	(Check only one)  2 Medical Examiner: On the basis of examination and/or invegored and manner stated.	estigation, in my opinion, death occur	rred at the time, date	and place, and due to the cause(s)			
	To the To the comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
	121		fourte Jane 1 ( on De	030948		3/1/07			
j	241		30. Name and address of person who complete cause of death (Item 23a) (Type, P )  AMES K. PORTERFIELD, M.D. 650  31. Date filed (Month, Day, Year)  MAR 0 2 2007  MAR 0 2 2007	rint) GBMC-PPW (	,000 	MASISAL			
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	DI IN CHARCLES S	·	IND ZIZOV			
	Registr	ar	MAR 0 2 2007 Descen &	ade					

		-	For State Registrar	State of Mar	yland / L	Departme Certifica				giene Reg. No. 🤈	007	0562	) [
	Physicia	1. Decedent's Name (First, Middle, Last)  Alexandria C. Maistros							2. Date of Death Month Day Year Solution 29 2007 0.55				М
į,	/Medic Examin	al	Alexandria C. Maistros February 28, 29  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County or							9:55 A			
<i>'</i>	Examin	ei	Hospice of Baltimo		st Cen		vson			Balti			
	Funeral Director		217-05-2038	7 M ON E	90	Yrs. If Uno	der 1 Year is Days	Hours Min.	8. Date of Bir (Month, Da Oct. 2	th y, Year) 6 <b>,</b> 1916	Coui	place (State or Fore ntry) t Virgini	
7	rland ow	ŀ	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	n or Location			-			10d. Inside City Lim	
22	e Mary a-f sh tified	ctor	MD N/A		Baltim	ore						1 XYes 2 □ I	Vo.
53	with th	Director	10e. Street and Number	Duive			Zip Code			10g. Citizen o	f What Cou	ntry?	
5	death v	Funeral	645 Stoney Spring	12. Was Decedent Ev	er in U.S.		L210	panic Origin? (Sp., Mexican, Puert		USA - 14. B	ace - Americ		
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			2 X No	Specify:	o nican, etc.)	Spec	lack, White, cify: whi		
5	"natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a	Decedent's U	sual Occupa work done de Luse retired)	tion uring most of wor	king cals	16b. Kind of	Business/In	dustry	
7	within iene. than the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Ac			nager fo		Enoch	Pratt	Library	
2	al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle	Maiden Surn	ame)		
yla	nould to I Ment narkec natic e	<u>ا</u>	Harry Cardiges  19a. Informant's Name/Relationship (7	ina Drint\	101	Mailing Addr		Maria Pa nd Number or Ru		or City or Tou	in State 7	Code)	_
Z	nd 2 sh lith and 27 Is n r traun		Harry C. Maistros			-		ing Driv					
, u	of Hea		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			f Disposition (i			Date	20c. Location			_
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j <sup>s</sup>	Physician /Medical Examiner	ľ	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):								_		
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UNISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined							8f. Location (Street and Number or Rural Route Number, City or Town, State)			_
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	To th within То th	Me	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Typerson who completed cause of dea				29c. License <b>D</b> <i>5</i> 8 3	number 303		29d. Date sig	ned (Month	Day, Year) 8 2007	
, 	le		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	cs St	Bern	ens 2	1204		,	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	y for	de						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 27, 2007 **Physician** 12:32 P M MONHEIT ARTHUR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 6714 CHOKEBERRY ROAD BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09/25/1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F NY 79 107-20-4453 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No BALTIMORE MD BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21209 6714 CHOKEBERRY USA items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 MY Yes 2 □ No WWII If Yes, Give Year or Dates: ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) EXECUTIVE WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANDROPHY ELIAS MONHEIT JEAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6714 CHOKEBERRY ROAD - BALTIMORE, MD 21209 DIANE MONHEIT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 03/01/2007 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician VV disease or condition resulting in death) 1a/ gnant /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No the 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Mo 24a. Was an autopsy performe 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of after death. i Director: After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

31. Date filed (Month, Day, Year) MAR 0 2 State Registrar

29b. Signature and title of certifier

3730 Falls 32. Paistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DHMH 17 Rev 1/2001

29c. License number

Itimore

29d. Date signed (Mpnth, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 200 400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical and 9. Birthplace (State or Foreign Country) Vary and 8. Date of Birth (Month, Day) Sex. 1 M 2 □ F **Funeral** Vear Vrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or Funeral Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Š 3 ☐ Widowed 4 ☐ Divorced lac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Mental ndre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp Code) 21244 19a. Informant's Name/Relationship (Type. Print) | Parents) Rida 27 7801 DOL Windsor Milli MD Eville Sr. permit. Pages 1 and Department of Healt important: If Item 2 any injury or other: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Hours Sequentially list conditions Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No this certificate has al director, page 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State Registrar MAR 02

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sharon Neal 26 2007 9 34 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALDMUN CIM SINM HOSPIME BARMENE Months Days Hours Min. 8. Date of Birth (Months P12 / 12 / 1953 Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 215-64-6738 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ne 23a or 28a-f ehov must be notified at 1 ☐ Yes 2 No MD Baltimore Gwynn Oak Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21207 6719 Meekins Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. or iteme 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Humanin Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Caregiver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marvin Thomas Neal Poppy Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rob Wright/Son 123 Bright Side Avenue Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 21. Signature of Funeral Service Licenses 22Cremation and Funeral Alternatives Land 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (SMGE 4 LING CONVERT 3 musines **Physician** /Medical Due to (or as a consequence of): Examiner mune LIVER Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time ot death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 □Unknown 2 No 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 우 Director: After this in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESUMM 26, 2007 P45-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0.0. 2401 W. Belvedere Ave. Baltimore, MD 21215 LETEMY M. 1/WK 22. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 02 Registrar

		•	state Amend #9, 10f	State of No. 15, perFH, s	Maryland / 3865, 3.19	Depa Cel	irtment of <i>tificate o</i>	Health a	and M	ental Hyg	iene g. No.	07	06429		
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E	Page nent o int: If		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		( <del>0</del>		rk Ceme		2/ 26	6/07	Bal <b>ti</b> :	more,	Maryland		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 2008.		21. Signature of Funeral Service L	Сылыян						don Par					
	Priysician /Medical Examiner		3620 Wilkens Ave. Baltimore, Maryland 21229  23a. Part. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Behaviore.												
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al H										perform	No No	death? 1 ☐ Yes	2 No		
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	5+1		30. Name and address of person of the Color	no completed cause o	f death (Item 23a	(Type,	Print) Healt	Scare		Baltin	ore,	Mary	13, 2007 land 21229		
	Sta Registr	1770	31. Date filed (Month, Day, Year)  MAR 0 2 200	32. Regi	Strar's Signature	best	E)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 27, 2007 **Physician** 4:00 P M TAMMYE PELOVITZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROCKVILLE MONTGOMERY CASEY HOUSE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 06/05/1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F MD 215-44-0730 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9259 HARVEST RUSH ROAD 21117 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No WHITE Specify: 2 3 ☐ Widowed 4 🕅 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)5+ Elementary/Secondary (0-12) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MENSH CECELIA KOLKER SAMUEL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1357 HILL BORN DRIVE - HANOVER, MD 21076 DAVID PELOVITZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 03/01/2007 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician s the burial Physician/Medical attending pr 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🔀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No death? 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No HOSPICE ٩ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Dilliamo DO

2-27-2007

CYNTHIA M. WILLIAMS, D.O.

2007

MONTGOMERY HOSPICE

ROCKVILLE, MD 20855 6001 MUNCASTER MILL ROAD

31. Date filed (Month, Day, Year) State MAR 0 2 Registrar

4 Homicide

29a. Certifier

Medical



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RUTH DO. 40 AM LILLIAN MARCH 02 200+ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner S BAYUIB BALTIMORE JOHNS HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12, 1948 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛣 F 212-46-6028 Maryland 58 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ntt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland | Baltimore Dundalk 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1902 Marsdale Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 years **Housewife** Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian E. Muth Harry N. Thiess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1902 Marsdale Road, Dundalk, Maryland Husband Richard Ruth Sr. permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State March Date 5 20a. Method of Disposition cemetery, crematory or other place) St. Stanislaus Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2007 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee 21222 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

EASTERN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FASHOYIN

31. Date filed (Month, Day, Year)

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AVENUE

MARCH 02, 2007

BALTIMORE MD

			For State Registrar	State of Marylar		artment of H			giene Reg. No.200	7 06432	
	Dhamini		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death	
	Physici: /Medic	-	Albert C. S	Silvia Jr.				Feb 2	28 2007	11:50ам	
1	Examin	er					4b. City, Town, or Location of Death			Death	
			928 Garden Dri		lant himboland	Esse:		Irs. 8. Date of Birt	Balt	imore	
	Funeral Director			M 2□F 62	. last birthday) Yrs.	Months Days		lin. (Month, Da)		Birthplace (State or Foreign Country)	
			Usual Residence of Decedent	02		l		Jan 9	1945	MAryland	
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
	a-fa	ctor	MD Baltimo	ore	Esse	x				1 ☐ Yes 2X No	
	ith the	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?	
	ath w	Ta l	928 Garden Dri			2122			USA	A	
98	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hydiene. Department of Heatile and Mental Hydiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified at ODGe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in the Armed Forces?</li> <li>1 ☐ Yes 2 In Note of Yes, Give Year or Dates:</li> </ol>		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc. White	
5-0036	hour	edt	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ness/industry	
5	n na	plet	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of	working			
2121	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Main	tanance			Polk A	udio	
힏	al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle,	Maiden Sumame)		
<u>a</u>	Ments Ments arked	ည	Albert C. Silv	via Sr.				phine La			
, Maryland	and 2 sho alth and 1.27 te m		19a. Informant's Name/Relationship (Typ. Linda Silvia /wi			ng Address (Street : Garden I		Rural Route Number Baltimo	or, City or Town, Sta ore MD 2		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		cemetery, cre.	osition (Name of matory or other place	(8)	Date	20c. Location - Cit		
<u>Ĕ</u>	Peg ment ant: h		4 □Donation 5 □Other (Specify)	Do		Cremato		3/07	Baltimo	re MD	
Baltimore,	permit. Departimport. any inj		21. Signature of Frida Service Upanse	( wells	. (1/	2. Name and Address Connelly				alto. MD ex 21221	
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	eations that caused the dea	th. Do not en	ter the mode of dyin	g, such as card	diac or respiratory ar	rest,	Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Metastatic Non Small Cell Lung Cancer & Month (Final Cause or Condition)								
			resulting in death)	Due to (or as a conse	quence of):				J	0	
	Ladillilei	<u>_</u>	Sequentially list conditions, b	Due to (or as a conse	quence of):						
1	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
V	al-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	quence of):						
8760,	sate be executed obysicien and the burial-transit	call	L.								
89	tificat ig phy as th										
Вох	th cer lendin r use	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		☐Ectopic pregnancy	,		23d. Date o		
П	res that the death certifica igned by the attending pl be deteched for use as t	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)			Month	Day Year	
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2	Jing I	ion	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe r	low injury occurred		
Division	death ctor: y the	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st			28f. Location (S	Street and Number of	or Rural Route Number.	
<u>&gt;</u>	after after Dira	Certification;	4 ☐ Homicide determined	building, etc. (Spec	ify)			City or Tou			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	edical C		sician: To the best of my knar: On the basis of examinand manner stated.							
	omple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (A	Month, Day, Year)	
			Dag of Con	they wan		DI	1.118	·	March	1 2007	
	/-		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type	, Print)	e lea	1	iwich	)	
	) Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Situ	144 ature	7 YOR	K R	d but	herville	MD 21093	
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DHMH 17 Rev 1/2001

Registrar

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			_ POI	State of Maryland					/ 1   1   1	06434
			- State Registrar		Cer	tificate of L	Jeath	2. Date of Deat	g. No.	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  LEO W	SCHROEL	DER			February	Day Year	4:00A M
,	Examin		4a. Facility Name (If not institution, give stre	net and number)		1	Location of Death		4c. County of Death	
			6512 Langdale Road			Baltimore If Under 1 Year	County If Under 24 Hrs.	10.5.1. (5:4)	Baltimore	(0)
l	Funeral Director		213 20 4717 7	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		ace (State or Foreign try) ,Minnesota
	and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·	11	Od. Inside City Limits
	Maryl fed	ō	Maryland Baltimore	Balt	timore C	ounty				1 ☐ Yes 2 ☐ No
	with the 3a or 28a 1 be notii	Director	10e. Street and Number 6512 Langdale Road			10f. Zip Code 21237		10	Og. Citizen of What Coun	try?
ဖွ	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene.  Department of Heelih and Mental Hyglene.  Department of Histor 27 is marked other then "natural" or items 23a or 28a-f ehow morphorent: if item 27 is marked other then "natural" or 12a marked other then permitted at environment in the Madical Examinar must be notified at once.	/ Funeral	1 ☐ Never Married 2 🔀 Married	Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give		Vas Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)	14. Race - Americ Black, White,	etc.
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	11				16b. Kind of Business/Ind	
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פַ	al Hyg	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
<u>yla</u>	ould b Ment Ment Ment Ment Ment Ment Ment	7	William F. August Hen						Clara Kruse	
Maryland 21215-0036	and 2 sh eith and 27 ie m er treum		19a. Informant's Name/Relationship (Type Janet M Schroeder (Husbi			g Address (Street a Langdale Ro			City or Town, State, Zip nd 21237	Code)
Baltimore,	ages 1 e ant of He it: if itam y or othe		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	emetery, cren	sition (Name of natory or other plac . Memorial (	<b>9</b> )		20c. Location - City or To Baltimore ,Mary	
aţį	mit. F partme sorter / injur		21. Signature of Funeral Service Licensee		-	. Name, and Addres assahn Fune				
<u>~</u>	perm Depa impo eny i		Mather Das	80 M	1 7	401 Relair	Road Ralti	morre Marry	land 21236	
			23a. Part1. Enler the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the death cause on each line.	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	SVII NO NE	Approximate Interval Between Onset and Death
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ה' כ	be executed icien and burial-transit	Examiner	Cause (Disease or injury that iniliated events resulting in death) Last	Due to (or as a conseq						
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P.0	d by the	Phy	9 ☐ Unknowń  Part II. Other significant conditions contr		ulling in the u	aderiving gause give	en in Part I	23e Did to	pacco use contribute to the	ne cause of death?
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Division of Vital Records,	: The law r cete has be page 2 sh	omple	STOMATITIS/I		5/DI/	4RRHE	A from	24a. Was a autops perform	y prior to con ned? death?	psy findings available inpletion of cause of 2 No
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<u>&gt;</u>	Physician: this certific al director.	10 E	1 ☐ Yes 2 No		ER/Outpatien		4 🗆 Nursing n		nce 6 Other (Specifi	)
ion	Attanding Physician: r death. ector: After this certific by the funeral director.	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yal k? Yes 2 □No	28d. Describe ho	w injury occurred	
Divis	al or Atta efter de Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location (St City or Town	reet and Number or Rura n, State)	l Route Number,
	To the Hoepital or Attanding I within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	Medical C		r: On the best of my known: On the basis of examination and manner stated.						
	To the twithin 2 To the I complet	Me	29b. Signature and title of certifier	1 - 2 - 11	0	29c. Licens	C	1	9d. Date signed (Month,	
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	'XA'		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type,	Print)	ADCIDO	#フロニ も	2/28/20 BALTIMORS	4021727
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	thre	-110 340	TKELK	" W 5 E	MILITURE	TOUR
×	Regist		MAR 0 2 2007	District Di	100					

LEO SCHROEDER

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		artment of H			iene	7	06436
	Physicia	an	1. Decedent's Name (First, Middle, Last)			7		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give:	- SPAHR		4b. City, Town, or	Location of Deat	MARCH	4c. County	007	8145 AM
	Examin	er	6225 EAST HE	· ·	=		SVILLE			RRO	LL
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year)		ace (State or Foreign try)
	Director		212 92 1223 19 Usual Residence of Decedent	42	Yrs.			NOV 22	1964	n	TARYLAND
	yland		10a. State 10b. County	-	, Town or Lo					10	Od. Inside City Limits
	Ba-f s	ctor	MO CARRO	المال	YKE	SVILLE					1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number 6225 EAST H	-EMINE MI	<i>U=</i>	10f. Zip Code	184	10	0g. Citizen of V	Vhat Count	try?
	death ms 23	nera		12. Was Decedent Ever in U.S		Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race	- America	
92	or Ite	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ( Year or Dates:	1	irYes, specity Cuba 1 □ Yes 2 <b>⊠</b> No	Specify:	to Mican, etc.)	Specify	k, White, 6	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int. It a Medical Exam ner must be notified at	ed b	3 Widowed 4 Divorced  15. Decedent's Edu			dent's Usual Occupa	ation		16b. Kind of Bu	WH	ITE
215	hin 72 9. An "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo.	rking	TOD. KING OF BU	3/11033/1110	ustry
7	ygiene ygiene ner tha		12	0	CARI	PENTER			Consti		ON
Maryland	d be fi	) Be	17. Father's Name (First, Middle, Last)  OONALY SPA	1+0			-	ne (First, Middle, N BETH H		•	
ary	should be ind Mental marked c	P_	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a					Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mardle Hygiens. Important: If item 27 is marked at the "natural", or items 23a or 28a-1 show mit potrant: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event. Its Medical Exam as must be notified at once.		SHARLENE MIST		6225	EAST H	tEMLOU!	ORIVE.	SYKESVI	UE.	10 21784 Mn, State
altimore,	Pages 1 nent of Hi int: If iter iry or oth	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		ımetery, crer	natory or otner piac	<i>e)</i> ' ' ' ' ' '				
ij	artmer artmer brtant Injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		14402	Caenari 2. Name and Address	s of Facility 12	1200 + F	HAMPSTO	SAO,	mu
Ba	permit. Departr Importa any Inje		Magny N. Zu	mbrum		028 SYK					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death							Approximate Interval Between
4	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	MOTADATIC	Hecv	12/PC	h (A	ncer		1	Onset and Death
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	₽ #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	unes al).						
h-	and l-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
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9	rtificating phy	Physician/Medical	IE ECHAIG.								
Вох	ath ce	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal	death 3[	Ectopic pregnancy			23d. Date Mor	e of deliver	y Day Year
P.0.	that the death certific ed by the attending p detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5∟	Other (specify)					,
	ss that gned b	by Pr	Part II. Other significant conditions cor	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	bute to the	e cause of death?
ord	w requires that been signed b should be deta	ted	Description	1000100	) S			1 □ Ye	s 2 No	3 Proba	ıbly 4 □Unknown
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ta 	ician: Th certificate rector, pag	0	25. Was case referred medical				26 Place of Dec		No 1		2 No
Š	Physician: r this certifica ral director, p	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 6	R/Outpatien	t 3 DOA Othe			nce 6 □Othe	r (Specify)	)
o uc	ding Phys h. After this o funeral dir		27. Mann of ≥ ath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occurre	ed	
Division	or Attendi efter death. Director: A in by the fu	ificat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor			Yes 2 □No	28f. Location (Str		er or Rural	Route Number,
á	tal or A	Certification:	4  Homicide determined	building, etc. (Specify,	)			City or Town	, State)		
	To the Hospital or Attending Physician: The within 24 hours elied death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca irred at the time, da	use(s) and mar te and place, a	ner as sta nd due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month, D	Pay, Year)
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	4		Dr Gaffar 555	S Centers	St. V	Vestmir	nster M	id alle	57		
	Sta Registr		31. Date liled (Month, Day, Year) MAR 0 2 200	3 Registrar's Signat	ure And	de					

			For Stata Registrar	State o	f Maryla		artmen rtificat				lental Hy	giene () ()	7 (	06437
	Dhamini		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	Day	Year	3. Time of Death
	Physici /Medic		J. King B.E.	Seegar, J	r., MD	)					Februa	ry 26, 2	007	9:35 A M
	Examin		4a. Facility Name (If not institution	n, give street and nur	nber)				Location of	of Death		4c. County o		
			Edenwald				Tows						imore	
	Funeral		5. Social Security Number	6. Sex 1 (2 <b>X</b> M 2 □ F		s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	<sup>th</sup> ΥθαΓ) 25, 1909	<ol> <li>Birthplace Country</li> </ol>	ce (State or Foreign yland
	Director		216-46-8822 Usual Residence of Decedent	102101	97	Yrs.					Oct. 2	25, 1909	Mar	ryland
	and		10a. State 10b. County		10c. 0	City, Town or L	ocation						10d	I. Inside City Limits
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	with the Maryland B or 28a-f show	rect	MD Baltir  10e. Street and Number	note	10	שפטח	10f. Zip	Code				10g. Citizen of WI	hat Country	1?
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Maryland 21215-0036	12 sh and ris m		19a. Informant's Name/Relations Jane I.S. Seega								ы <i>Route Numbe</i> Wson, M	er, City or Town, S D 212		ode)
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		20a. Method of Disposition	ar (mric)	20h	. Place of Dispe		,	Nodu		Date T	20c. Location - C		Ctata
Baltimore,	0 0		1 Burial 2 Cremation	3 Removal from	State	cemetery, cre	matory or o	ther place			- 1			
Ħ	permit. Pag Department Important: I any injury o		*4 □ Donation *5 □ Other (S 21. Signatu/e of Funeral Service	_	[H]							Towson,		
Ba	permit. Page Department Important: II any injury o		21. Signature of Francisco	Ciceris								on Funer ryland	aı no 21204	
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′ ,	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	or as a cons	equence of):	8		- 3	-01	1000		_	
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.89	ficate g phys as the	Ø.												
Box	eath certific attending p for use as f	Physician/M	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, out			70					23d. Date	of delivery	
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tal	. 48 07	e C	25. Was case referred to medica	1					26. Place	of Death	1 ☐ Yes	4		
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ا م	Jing Ph J. After thi funeral	ı. T	27. Man or of Death	28a. Date	of Injury h, Day Year)	28b. Time o	of 2	8c. Injury Work	_	_		low injury occurred	()/	
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18	Sta Registr		SEAD O	2 2007	SUASUR	B A	perte	•			J			

9.35 B.M.

FEBRUARY

JOHN KING SEEGHE

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25,2007 Yea 11**:**23 Р м TRIVAS FEBRUARY STANLEY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 1 Year | If Under 24 Hrs. Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/26/1934 Age (In yrs. last birthday) Social Security Number Months 1**√** M 2□ F 218-28-6239 73 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 No BALTIMORE TIMONIUM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 660 STRAFFAN DRIVE #105 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 💢 No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ACCOUNTING C.P.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TRIVAS SADIE **FRIBUSH** MAX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 STRAFFAN DRIVE #105 - TIMONIUM, MD 21093 MARLENE TRIVAS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BETH EL MEMORIAL PARK: 02/28/2007 RANDALLSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner certificate be executed burial-transit and

attending physician for use as the buria

certificate has

neral Director: A rilled in by the for

al or Attending F s after death.

To the Hospital of within 24 hours af To the Funeral D

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

To Be (

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

Physician/Medical þ Be ဥ

Certification:

Medical

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an autopsy performed 2 No

26. Place of Death Check onl one

4 ☐ Nursing Home

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 251 No 27. Manner of eath 1 Natural 2 Accident 5 Pending

3 ☐ Suicide

investigation 6 Could not be determined

Inpatient Date of Injury (Month, Day Year)

Hospital:

2 ER/Outpatient 3□ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) KODNEY

31. Date filed (Month, Day, Year)

32. Registrar's Signature

6701



DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18:30 PM Day Month Year **Physician** February 2007 an ance /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center

| 6. Sex | 7. Age (In yrs. last birthday) Social Security Number Battimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2**X** F Hours 247-28-8017 South Carolina Director June 6,1923 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Baltimore Dundalk Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 200 Pinewood Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes XXNo Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lizzie O'Neal D.C. Watkins ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 Pinewood Road, Dundalk, Md. 21222 Husband Arthur Vance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 1. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 5 Other (Specify) 2007 4 □ Donation 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 21. Signature of Funeral S 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe preumonia week /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-trai Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 4 ☑ No page 2: 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 🔲 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) grenus BALTIMORE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 02 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Box 68760. Records, P.O. Division or Vital

Hospital or Attending Physician: within 24 hours after or To the Funeral Direct completely

Registrar

Medical

J. CHANNES, 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MAR 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

February

29d. Date signed (Month, Day, Year)

26 2007

N. Charles of Bosonne as 21204

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wirth February 21, 2007 1:27 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Collington Nursing Home Mitchellville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Director 211-22-2571 102 4, 1904 Germany Aug. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 X No Director Maryland Prince George's Mitchellville 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 'natural", or items 23a #144 10450 Lottsford Road 20721 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Project Manager US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karl P. Wirth Sophie H. Huebner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Elsa Willis - Daughter 20816 Noble Terrace #312 Potomac Falls, VA 20165 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 3/2/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 201 Edwards Ferry Rd. NE Colonial Funeral Home Leesburg, Virginia 20176 Uneu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) auteny **Physician** ovonavy 10 years /Medical Due to (or as a consequence of) **Examiner** ecteusion Sequentially list conditions, it any learning terms to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine dys vy Horia Higlory ot Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ Ro 3 ☐ Probably 4 ☐ Unknown Carcinoma Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 21 No death? certificate 2∭ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 No မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending I Director: A 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by filled in by determined 4 ☐ Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0

State Registrar G. CHAMPALOUX

2. Registrar's Signature

31. Date filed (Month, Day, Year)

MD\_14314 old Manlboro Pike. Upper Macyboro, MD 20772

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Noel Η. Whiting /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Blakehurst Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 92 218-12-7112 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Baltimore Md. Towson Director 10e. Street and Number 10f. Zip Code 21204

2. Date of Death February 28, 2007 12:50 p M 4c. County of Death Baltimore 8. Date of Birth Oct. 15, 9. Birthplace (State or Foreign Mary and 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? 1055 W. Joppa Rd. #230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White <u>\$</u> 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josefa Mathilde Noel Brooke Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 311 Chatolanee Hill Owings Mills, Md. 21117 Mr. G. William C. Whiting/ Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Hilltop Service Co. 3-2-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Na</sup>Ruck <sup>Ad</sup>Tows of livyFuneral Home, 1050 York Rd. Towson, Md. 21. Signature of Juneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Debuly

Reg. No.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

sician and burial-transit

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

death.

Box 68760,

P.0.

Division or Vital Records,

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autops, performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and itle of certifier

HAMBUD 6701 N, Charly ST Brown us ZIZUA 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrer	State of Ma	ryland			nt of He te of D		ind M		giene Reg. No.	007	06443
	Physicia	20	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Iris Ann Bro					<u> </u>	== .101		Feb.	20,	2007	10:52 P M
	Examin	er	4a. Facility Name (If not institution, give 306 W. Sunset					, Town, or L		l Death			inty of Death	
			306 W. Sunset .		(In yrs. las	st birthday)		reens	If Under 2	24 Hrs.	8. Date of Birt	h	oline 9. Birthi	place (State or Foreign
	Funeral Director				9	Yrs.	Months		Hours	Min.	(Month, Da)	v, Year)	Cou	ntry) ginia
			Usual Residence of Decedent											
	show		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits  1X□ Yes 2 □ No
	88a-f	ecto	MD Caroli	ne	Gree	nsbor		0-1-				10a Citizan	of Milhot Cour	
	with ti	D	10e. Street and Number 306 W. Sunset	Arros DO Po	sr 57			p Code 1639					of What Cou	ntry r
	eath is 23	Funeral Director	306 W. Sunset	Ave; PO Bo		. 13. \			nanic Orio	nin? (Spe	cify Yes or No		S.A.	can fndian,
2	r them	Fig	1 Never Married 2 Married	Armed Forces?		1	f Yes, sp	ocify Cuban	, Mexican	, Puerto I	Rican, etc.)	E	Black, White,	
Š	Pai', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			¹ ∐ Yes	2 <b>X</b> No	Specify:			Spe	ecity: Wh	nite
ה ה	should be filed within 72 hours after death with the Maryland and Montal Hygiene. marked other than "natural" or tiems 23s or 28s-f show marked other than "natural" caminer must be notified at mail or notified at	Completed	15. Decedent's Ed (Specify onfy highest gra	ucation de completed)		16a. Deced (Give	kind of w	ork don <i>e</i> du		of working	ng	16b. Kind o	f Business/Ir	ndustry
7	vithin ne. hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite. L		use retired)					N/A	
7	Hygie Hygie ther t		0 17. Father's Name (First, Middle, Last)				Dis	abled	18. Mothe	r's Name	(First, Middle,	Maiden Sun		
<u> </u>	d be	To Be		Brooks					Iri	s F	e11			
<u> </u>	shoul nd M mari	-	19a. Informant's Name/Relationship (1	Type, Print)		19b. Mailir	ng Addre	s (Street ar			Route Numbe	r, City or To	wn, State, Zij	o Code)
Ě	aith a aith a 127 th		Dr. Howard E. Broo	ks/ brothe	r	306	W. S	unset	Ave;	PO	Box 57	; Gree	nsboro	, MD 21639
บ์ ว	of He fitem		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Pla	ce of Dispo	sition (Nation)	ame of other place,	,	D	ate	20c. Location	on - City or T	own, State
	Pag ment ant: i		4 ☐Donation 5 ☐ Other (Specify	1)	Cape	Char	1es	Cemete	ery 2	2/26/	2007	Cape	Charle	s, VA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deportment of Health and Mental Hygiene importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen	See Carlo				nd Address			ein Fu	seral 2163	Home,	PA
	Physician / Medical Examiner purisher purisher and purisher and the purish runsh	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a conseque	ence of):	te		Ais	eas	5 <u>-</u> 2.			Onset and Death
O. BOX 00	The law requires that the death certificate be sie has been signed by the ettending physicis bage 2 should be detached for use as the but	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal c	death 3	Ectopic Other (	pregnancy specify)				23d.	Date of deliv	rery Day Year
coras, r	uires tha signed lid be del	ρ	Part If. Other significant conditions of		ut not result	_	nderlying	cause giver	n in Part I.		23e. Did to	3.0		the cause of death? bably 4 Dunknown
Teco Teco	60 S CI	Completed		'							24a. Was autop	an 24	4b. Were auto prior to co death?	opsy findings available ompletion of cause of
<u> </u>	ysician: The I is certificete ha director, page										1 ☐ Yes	2)29No	1 ☐ Yes	2 No
=	sicial certii recto	o Be	25. Was case referred to medical examiner?	Hospital:	nt 205	R/Outpatier	nt 3□ [				(Check only one 5 Resid		Other (Cons	4.4
5	Physical distribution	<b>-</b>	27. Manner of Death	28a. Date of fnju	ry 2	28b. Time o		28c. Injury Work			28d. Describe I			(Y)
<u> </u>	nding Ph ath. r: After th e funerel	ation	1 Solatural 5 Pending 2 Accident investigation	(Month, Day	y Year)	Injury	М		/ es 2 🗆 l	No				
DIVISION	pitel or Atten ours after deat teral Director: filled in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At hon c. (Specify)	ne, larm, str	reet, lacto	ory, office			28f. Location (S City or Tox		umber or Rur	al Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medicai (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	nysicien: To the best niner: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurre vestigation	d at the time	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as s ce, and due t	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier		Na.	7	2	9c. License				29d. Date sig	gned (Month,	. Day, Year)
					10			200	53	2>	>	0/	21/0	07
			30. Name and address of person who								_			
			Melinda Butler, M  31. Date filed (Month, Day, Year)	D 136 L 32. Registr		Ave;	Pr	eston,	MD	2165	5			
I	Sta Regist		S. Salo mod (mornin, Day, Four)			30 0	8 0	,						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Earle Lyden Breeding FEB. 1:25AM 16, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1**∑** M 2□ F 78 218-24-5089 July 16, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Dorchester Federalsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6964 Reliance Road 21632 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 148-52 Year or Dates: 148-52 1 Never Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Auto Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Body Shop Owner and Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earle Linsley Breeding Ethel Agnes Robinson Breeding Workman 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6964 Reliance Road, Federalsburg, MD

Easton, MD 21601

**Physician** /Medical

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Janice Lynne Breeding/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Dennis M. DeShields, M.D. 219 S. Washington St.,

32. Registrar's Signature

**Funeral** 

Director

ıral", or items 23a or 28a-f show I Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Directo

Funeral

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72 hours after

21215-0036

Maryland

Baltimore,

eeding

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Examiner

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Pe Funeral Director: A pletely filled in by the full

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

	20a. Method of Disposition	TD-married from Otata	20b. Place of Disposition cemetery, cremator	n (Name of ory or other	place)	Date	20c. Lo	cation - City o	r Town, State	
	1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the contro		Eastern Sh	. Vet	erans 02/20	0/07	Hur1	lock,	Maryla:	n d
1	21. Signature of Funeral Service Lice	nsee	22. Na	ame and Ad	dress of Facility Fr	omnt E		1 11		
	Christine	m. Coa	le 216	N. Ma	ain St., ]	amptom r Federalsh	uner	al Home _MD 21	e, P.A. 632	
	23a. Part1, Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	ne death. Do not enter th	ne mode of	dying, such as cardi	ac or respiratory a	rrest,		Approximate Interval Bety Onset and D	veen
ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Cene	ے دری ہے consequence of):	Car	rdiom-	10 at	1-1		Onset and L	Jean
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اير	Sequentially list conditions,		consequence of).	- 7	140ra	Ett	~ ~	10-		
completed by Litysicial integral Evaluated	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a t	consequence or,							
9	that initiated events resulting in death) Last	C								
<u> </u>		Due to (or as a c	consequence of):							
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	IF FEMALE;							_		
	23b. Was decedent pregnant	23c. If yes, outcome pf		opic pregna	nov.		2	3d. Date of de	elivery	
	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tir		her (specify				Month	Day Y	ear
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	Part II. Other significant conditions	contributing to death but	not resulting in the under	lying cause	given in Part I.	23e. Did to	obacco u	se contribute	o the cause of de	eath?
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١						24a. Was autor	osy	prior to	utopsy findings a completion of ca	vailable use of
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1	25. Was case referred to medical examiner?					eath (Check only o	ne)			
	1 ☐ Yes 25 No	Hospital:	2 ER/Outpatient 3	DOA (	Other: 4 Nursing	Home 5 ☐ Resid	dence 6	Other (Spi	ecify)	
	27. Manner of Death  ↑ □ Natural 5 □ Pending	28a. Date of Injury (Month, Day )	28b. Time of Injury	28c. li	njury at Vork?	28d. Describe I	now injury	occurred /		
	2 ☐ Accident investigation	n	· · · · · · · · · · · · · · · · · · ·		☐Yes 2☐No					
	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of injury building, etc.	- At home, farm, street,	factory, offi	ce	28f. Location (S	Street and	d Number or F	ural Route Numb	oer,
	. L. Tormoldo	building, etc.	(Opecny)			City or Tov	vn, State)	•		
ŀ	29a. Certifier Tertifying Ph	ıysician: To the best of	my knowledge, death oc	curred at the	e time, date and plac	ce, and due to the	cause(s)	and manner a	s stated.	
	(Check only 2 Medical Examone)	miner: On the basis of e and manner state	xamination and/or invest	igation, in n	ny opinion, death occ	curred at the time,	date and	place, and du	e to the cause(s)	
	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date	e signed (Mon	th, Day, Year)	
		110	10.00	DRO	53110	,				
L	Jenn	101 000 3	July	> 100	/ > 110		L. C. P	ruan	7 16 2	007

State Registrar

within 2

homas Craig		1- For State Registrar	ate of Maryla		rtment of tificate of		Mental H		teg. No. 20	07 0644
Physicia Medical Examir		1. Decedent's Name (First, Midd Thomas I. Cr	-,,					2. Date of Dea Month February		3 Time of Death 0758 hrs
		4a Facility Name (if not institute	on, give street and nu	mber)	J	4b. City, Town, or L	ocation of Death	rebluary	4c. County of	
Funeral		Anne Arundel Medica  5. Social Security Number	Center  6. Sex	7. Age (In yrs. Ia	est hirthday)	Annapolis  If Under 1 Year	If Under 24Hrs.	le Data et a:	Anne Aru	
Director		217-96-2659	1 M 2 F	29	Yrs	Months Days		_	F	9. 8 irthplace (State or Foreign
		Usual Residence of Decedent					<u> </u>	2/25/	19//	Country) Maryland
iow any		10a. State 10b. County	1 1		Town or Locati	ion				10d. Inside City Limits
Aaryland 28a-f show	Director	Maryland Anne A	runder	Cr	ofton_	10f. Zip Code		Į i	0g. Citizen of What	1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once		2332 Westport	Lane			21114	i		USA	•
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Exantiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 XM		edent Ever in U.S rces?		s Decedent of Hisp es, specify Cuban,			)- 14. Race - / White, e	American Indian, 8lack, etc.
fter de l'', or i			1 Yes orced If Yes, Give Year	2 X No	1	Yes 2 X No	specify:		Specify	B1ack
hours a natura Exanii	ed by	15. Decedent's Education (Spe				t's Usual Occupation			16b. Kind of Busin	ness/Industry
336 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1- 2 years	,		C Foreman		<i>-</i>	Heating	and ditioning
11215-0036 Id be filed within 72 hours after fental Hygiene narked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle,	Last)				8.Mother's Name		Maiden Surname)	dicioning
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	To Be	19a. Informant's Name/Relations	Robin Crai	-g	10h Mailine	Address (Street		Witter	n nber, City or Town,	
AD 2 sho 27 is mati		Kristine V. Cr							, Marylan	
rre, s I an ff Hea If iten		20a. Method of Disposition  1 X Burial 2 Cremation	Removal fro			tion (Name of ceme		Date	20c. Location - Ci	
Baltimore, permit. Pages I an Department of He Important. If ite injury or other tr	ļ	4 Donation 5 Other S	pecify:	Lak		Cemetery		07	Davidso	nville, MD
Bal permii Depar Impo		21. Signature of Funeral Service	Licensee		22. N 297	ame and Address o	of Facility Geo ne Telan	orge P.	Kalas Fu	neral Home , MD 21037
Physician	7	23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death.	Do not enter th	e mode of dying, s	uch as cardiac or	respiratory are	est shock or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	a_ <del>Cardio</del>	negaly in	ntoxica					8 etween Onset and Death
September 1900 -	ĺ	or condition resulting in death)  Sequentially list conditions,	Due to (or as a b.	consequence of	):					
	ine.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	tansequance of	j.					
E (4)	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	):					
		X UNPENDED	d.	23a,PIT	,27,285	-f. ports	G885 1	1/26/08	TT	
60, ate be a shysicia	Medical	IF FEMALE:	"#23a,P.	II,27,perl	Œ, G866,	- 4/12/07 T	Γ		23d. Date of del	livery
30x 6876 death certificate e attending phy for use as the l	Physician/M	23b. Was decedent pregnant in the past 12 months?	I Live bil	th int at time of dea	oth -	al death 3	Ectopic pregnar	псу	Month	Day Year
Box te death the atte	ysic	1 Yes 2 No 9 Unit			5 Oth	ner (Specify)				
ires that the signed by 1	g B	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
ords, F	g	Cocaine use						24a. Was a		Probably 4 Unknown e autopsy findings available
e law r re has b	Completed	CArdiomegaly	7					autop: perfor	sy prior med? deat	to completion of cause of h?
tal Reco	ابه	25. Was case referred to medical				26.Place o	of Death (Check o	1 ✓ Yes :	2 No 1 🗸	Yes 2 No
Vita hysicia this ce		examiner? 1 ✓ Yes 2 No		patient 2 🗸		o Don	ther Nursing	Home 5	Residence 6 (	Other:
nding Pt nding Pt th. : After e funeral	ü	27. Manner of Death  X Natural 5 Pend	ling	Day,Year)	28b. Time of Ir	1 √ye		28d. Describe h unk	now injury occurred	
/iSiOP	ertification:		tigation Fdn Z	/ 24 / 07   of Injury - At ho	Fnd 6: me, farm, stree	55 am t, factory, office bui			Street and Number of	r Rural Route Number, City
Divisior - Hospital or Attend - A hours after death - Funeral Director: stely filled in by the	′ າ ⊢	4 Homicide deter	mined (Specify)	Rehal	bilitat	ion Cente	er A	rundel	County, N	ns, Anne
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	ल्र		nysician: To the best miner: On the basis of and manner_sta	examination an						
	žΪ	29b. Signature and title of certifie				29c License			29d Date signed	
	-	Mayorta J	melshele	of dooth /line :	230)	O.C.M	.E.		February 25,	2007
		<ol> <li>Name and address of person Margarita Korell MD.</li> </ol>	Assistant Medi			enn Street, Bal	timore, MD 2	1201		
Sta Registr	-	31. Date filed (Month, Day, Year)		istrar's Signatur	Spark	p				
	_	THE PARTY OF THE P	The state of the s	-	d					

			1 - For State Registrar	State of Mar	yland / D	epa <i>Cer</i>	rtment of F tificate of	łealth and <i>Death</i>	d Mental Hy	giene Reg. No.	2007	06446
	·		1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath	V	3. Time of Death
	Physici /Media		James Elmer	Cole, Sr.					Feb.	20.	2007	12:33 PM
i i	Examir		4a. Fecility Name (If not institution, giv				4b. City, Town, o	r Location of De	ath		County of Death	
			Caroline Home fo				Dento			Ca	aroline	
	Funeral		5. Social Security Number 6. S	EM SUE	In yrs. last birtl		If Under 1 Year Months Days	If Under 24 H Hours M		rth ay, Yeer)	9. Birth	place (State or Foreign intry)
	Director		220-01-3315 Usual Residence of Decedent	X 85	Y	rs.			11/12/	1921	Mary	land
	land ow		10a. State 10b. County	1	I0c. City, Town	or Loc	cation					10d. Inside City Limits
	Mary feth	ŏ	MD Carol	ine	Ridge	1 17						¥ Yes 2 No
	r 28a	Director	10e. Street and Number		KIUge	- <u>-</u> y	10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	ier deeth with the Marylan iteme 23a or 28a-f ehow at must be notified at	ai D	23767 Seward R	oad			216	660			U.S.A.	
	deetl	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of H	ispanic Origin?	(Specify Yes or N	o- 1	4. Race - Ameri	
5-0036	2 should be filed within 72 hours after deeth with the Maryland and Meniel Hygiene. Is marked other than "natural", or iteme 23a or 28a-f ehow aumatic event, the Medical Evand at must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Xes 2 No tf Yes, Give Year or Dates: 1			Yes, specify Cuba	Specify:	впо Hican, etc.)		Black, White, Specify: Wh	etc. iite
o Q	72 ho	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. I	Deced	ent's Usual Occup	ation	undring	16b. Kin	nd of Business/Ir	ndustry
2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			aind of work done of NOT use retired					
	filed w Hygier other th		07		Fc	ren	nan - Hig				ite of M	aryland
and and	2 2 2 S	Be	17. Father's Name (First, Middle, Last) Charles H. Cole						lame (First, Middle	, Maiden S	Sumame)	
$\frac{3}{2}$	should nd Men marke umaric	2		E D	405	6.4. Tet		Grace		· ·		
Maryland 2	is 1 and 2 should of Heelth and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship ( Margaret Jean DeFe						Rural Route Numb			Code)
	1 and 2 Heelth tem 27		20a. Method of Disposition	ord/daugnte	20b. Place of I	Dispos	ition (Name of		idgely,		.660 ation - City or To	own State
ē			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi				atory or other place Cemetery	1	3/2007			
Baltimore,	permit. Page Department Important: If any Injury of once.		21. Signature of Funeral Service Licer		RIUGEI	22.	Name and Addres	ss of Facility			gely, M	
	40240		23a. Part1. Enter the disease, or com	ley hat sourced the	o dooth Door	PC	B8x 160	; Green	nbein Fu sboro, M	216	3901112,	
			shock, or heart failure. List only	one cause on each line.	e death. Do no	ot ente	r the mode of dyin	g, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
\$	Physician /Medical		disease or condition resulting in death)	a. Tuel	MO.	UK	<b>3</b>					week
П	Examiner			Due to (or as a c	consequence of	t):						
	عد	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequence of	1):						
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events	C.								
Š,	ficate be executed physicien and is the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of	f):						
08/P0	cate b	edicai		. d		_						
_		Me	IF FEMALE:	23c. If yes, outcome of						T		
O. Box	law requires that the death certif es been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ory Day Year
ב,	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the un	derlying cause give	on in Part I	23e Did t	obacco ue	a contributa to th	ne cause of death?
vital Records,	n signe	d by	Chronic Ol	struct	TV	P	MONE	aryDis	cax 18			ably 4 Unknown
င္ပ	s been si	olete							24a. Was		24b. Were auto	psy findings available
Ÿ	The la	Completed							autoj perfo	osy ormed?	prior to co death?	mpletion of cause of
Ē	ian: rtifica	a)	25. Was case referred to medical					26. Place of D	1 ☐ Yes	2DNo	1 🗆 Yes	2 No
>	nysic nis ce direc	To B	examiner?	Hospitat: 1 ☐ Inpatient	2 ER/Outp	patient	3□ DOA Othe		Home 5 ☐ Resi		Other (Specif	المرابع المرابع
0	ng Pł		27. Manner of Drath  1 Naturat 5 Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Tir	me of	28c. Injury Work		28d. Describe			has piece
<u>0</u>	eath. or: A the fu	cati	2 Accident investigation				M 1 🗆 '	Yes 2 □ No				
DIVISION	al or At s efter d al Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Hornicide determined	28e. Place of Injury building, etc. (	· At home, farm Specify)	n, stre	et, factory, office		28f. Location (. City or To	Street and vn, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 (Check only one) 1 (★Certifying Ph 2 ← Medical Exam	ysician: To the best of n liner: On the basis of ex and manner stated	camination and/	death or inve	occurred at the time estigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	ind manner as si place, and due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	0/	$\overline{}$		29c. License	number		29d. Date	signed (Month,	Day, Year)
}			Jame	5 Side	es	9	S DE	3137	763	2-	22-0	う
			30. Name and address of person who							-		
				0 Market St		)ent	ton, MD 2	21629				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	E M	att.					

07-01415 James Douglas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Douglas		- For State Registrar	Sta	ate of Maryla		artment of <i>rtificate of</i>		id Ment	al Hygier		No 200	7 0544
Physician Medical Examine	1	1. Decedent's Name							Mor	e of Death	Day Year	3. Time of Death
wedical Examine		JAME: 4a. Facility Name (if		DOUGLAS		14	b. City, Town, o	r Location o		ruary 20	0, 2007 4c. County of Dea	
	Ļ	1595 Oposs					Frederick				Frederick	
Funeral Director		5. Social Security No.		6. Sex	7. Age (In yrs.   30	last birthday) Yrs.	Months Day		Min		(MM/DD/YYYY) 9. B Fore	
	-	Usual Residence of	Decedent						1 110		, 1570	
ow any	1	10a. State MD	10b. County			Town or Locati						10d. Inside City Limits  1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	3-	10e. Street and Num		e Georges	16	mple Hi	10f. Zip Code			100	g. Citizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once.		2420 Ive	rson S	treet			2074	8			USA	
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene iten 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once		11. Marital Status  1 X Never Marrie	d 2 Ma	A			s Decedent of Hi es, specify Cuba				14. Race - Ame White, etc.	rican Indian, Black,
fter des	-	3 Widowed		1 Yes	2 X No	1	Yes 2 X No	specify:			Specify: B	lack
5-0036 led within 72 hours aft Hygiene Other than "natural" the Medical Examine				or Dates: cify only highest grade			t's Usual Occupa ost of working life			ne 1	16b. Kind of Business	/Industry
5-0036 ed within 72 hour hygiene other than "matt	ible l	Elementary/Secon	ndary (0-12)	College (1-	4 or 5+)	Assemi	oly Line	Work	er	İ	AeroSys	
215-0036 be filed within 7 ntal Hygiene ked other than ent, the Medica		17. Father's Name (I	First, Middle,	Last)				18. Mother's	s Name (First,		aiden Surname)	
2121 buld be fill Mental F marked ic event,	5 T	Robert I		nip (Type, Print )		19b, Mailing	Address (Street		n Doug		er, City or Town, Stat	e, Zip Code)
and 2 shou tealth and N ten 27 is n traumatic	1	Ellen Bai				12420	Iverson Hills,	St.	20748			
ore, MC		20a. Method of Disp 1 Burial 2		3 Removal fro		Place of Disposi crematory or oth		metery,	Date		20c. Location - City o	r Town, State
Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra	Į,	4 Donation 5			Me	etropoli	tan Cre	mator	y 2-21-	2007	Alexandri	a, Va.
Ba perm Depa Impo	Ţ	S. P.	ma	skril		142	ame and Addres CShall S 17 9th S	t. N.	W. Was	shing	ton, DC 20	0011
Physician // // // // // // // // // // // // //	1	2 a art I. Enter the failure. List only	e disease, or y one cause	complications that ca on each line.	used the death	. Do not enter th	e mode of dying	such as ca	rdiac or respira	atory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (F or condition resulting		a Smoke in								Death
		Sequentially list con		b								
ted nisit		if any, leading to imr cause. Enter Under (Disease or injury th	lying Cause	Due to (or as a c	consequence o	of):						
d d ansit		events resulting in d		Due to (or as a d	consequence o	of):						
ox 68760, ant certificate be executed attending physician and or use as the burial - transit	<u>ק</u>	X UNPENDED		AMEABED, 2	7,28a-f,	perME, g	365 <b>,</b> 3/7/0	)7 TT				
876C iificate ng phys	2	F FEMALE: 3b. Was decedent p	regnant in th	23c. If yes, o	utcome of preg	nancy	al death 3		pregnancy		23d. Date of deliver Month	ry Day Year
Box 68760, a death certificate be the attending physic of for use as the buring by since the series of the series	200	past 12 months?		nown 9 Unknow	int at time of de	- 41.	ner (Specify)					
D. Bo	<u> </u>			ons contributing to		resulting in the u	nderlying cause	given in Par	tl. 23	se. Did toba	acco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director.	ν. Σ								— L			bably 4 Unknown
Records,   The law requires ficate has been sig. page 2 should be	blet					·			24	a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Rec	5	OF Man ann refere	ad to modical				26 Place	of Death //	1 Check only one	Yes 2		es 2 No
Vital ysician ysician directo	۱ ۵	25. Was case referre examiner? 1 ✓ Yes 2	r	Hospital: 1 In	patient 2	ER/Outpatient		Othor	Nursing Home		esidence 6 🗸 Othe	er: Scene
ing Ph After ti funeral	- 15	27. Manner of Death			of Injury Day,Year)	28b. Time of Ir		ry at Work?		escribe ho	w injury occurred	
Sior Attend r death ector: by the		2 Accident	T/*	tigation Z/19/Z		12:47 pt	11 }	Yes 2 X	unita		eet and Number or R	ural Route Number, City
Division o spital or Attending hours after death. neral Director: After filled in by the func		3 Suicide 4 Homicide		mined (Specify)	Build:		,	3.	Free	Town Sta derick	te) 1595 Oposs , MD	ural Route Number, City Junitowne Pike
		29a. Certifier (Check only one)	Certifying Ph	nysician: To the best	of my knowled	ige, death occur	red at the time, d	ate and place	ce, and due to	the cause( ne, date ar	s) and manner as stand place, and due to t	ted he cause(s)
To the H within 24 To the F completel		29b. Signature and t		and manner st			29c. Licens				29d. Date signed (Mo	
		10 as	lock	eun			O.C.	M.E.			February 21, 20	07
0	+			who completed causessistant Medical			Street, Baltin	more Mr	21201			
Stat	2	Laron Locke 31. Date filed (Mont)					Olieel, Dailli	HOLE, WIL				
Registra	,	31. Date filed (Month FEB 2	6 2007	hair	1.	Speck						

DHMH 17 Rev 1/2001 OCME 2006

		1 - For State Regis	strar		Sta	ate of M	aryland		artmen rtificate				lental H	ygiei Reg. i	00	107	06648
Ohu			nt's Name	(First, Middle	, Last)								2. Date of I		Day	Year	3. Time of Death
	siciar edica		Ad	ell D	ownin	g							Februar		2, 200		11:30PM
Exa	mine	4a. Facility	Name (If	not institution	, give street	and number)			4b. City,	Town, or	Location of	of Death			4c. Count	y of Death	
		_		g Cou							sbu				Wi	comi	CO
Fune		5. Social S	Security Nu	mber	6. Sex 1 ☐ M 2		e (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, L	irth Day, Ye	ar)	9. Birth	place (State or Foreign
Direc	tor	219-0 Usual Res				-X.	86	Yrs.					Dec.		1920		ginia
and w		10a. State	т.	10b. County			10c. City, 7	Town or L	ocation								0d. Inside City Limits
Maryl f •hc	Š	MD		Wicom			G - 1	2 . 1.									1 ☐ Yes 2 ☑ No
the 1		10e. Stree	t and Num		100		Sal	lisbu	10f. Zip	Code				100	Citizen of	What Cour	<u> </u>
with 3a or	١	160	) O III -	c Cour	<b>+</b>						1					Wilat Coul	id y :
Jeath	0,10	11. Marita		g Cour	12. Wa	s Decedent	Ever in U.S.	13.		2 180 lent of Hi		gin? (Spe	city Yes or N		USA 14. Ba	ce - Americ	an Indian
Dalitimore, Maryland ZIZID-UU30  sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  mportant: If ten 27 is marked other than "netural", or teme 23a or 28a-7 show my nitury or other trainmaric asset.	by European	3 <b>⊠</b> W		id 2□ Marri I□Divorced	ed 1 [	ned Forces? Yes 2 📈 'es, Give ar or Dates:			If Yes, spec			, Puèrto	ecify Yes or N Rican, etc.)		Bla	ick, White, fy: Bla	etc.
72 hg	Completed		(Specif	15. Decedent	's Education	v(atad)	1	I6a. Dece	dent's Usua	l Occupa	ition			16b.	Kind of E	Business/In	dustry
L L	1 2	Element		y only highes dary (0-12)	T	llege (1-4or 5	5+)	life.	kind of wor DO NOT us	k done d e retired,	<i>uring</i> mosi )	t of workii	ng .	Sal	ichur	y Nurs	ing s
filed withi	į		6th						Labo	orer							n Center
aryland Z should be filed v and Mental Hygie marked other t	9		's Name (F	First, Middle, I	_ast)						18. Mothe	r's Name	(First, Middi	e, Maid	en Sumai	пе)	
Ment to a street		Fra	nk B	adger							Cá	arri	е				
2 sho and and is my		19a. Infor	mant's Nar	ne/Relationsh	nip (Type, Pri	int)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	l Route Num	ber, City	or Town	, State, Zip	Code)
S 1 and 2 should at Health and Mer Item 27 is marke		Alice	e Tho	mas/Da	ughter				4 4		urt •	- Bea	ar, DE	197	01		
or series		20a. Metho		sition Cremation	2 CB		20b. Plac	e of Dispo	sition (Nam	ne of ther place	)	D	ate	20c.	Location	- City or To	wn, State
DAILLINOR  permit. Pages 1  Department of H  Important: If Ite				Cremation 5 ☐ Other (Sc		ii from State			-		· 1	eb. 16	5, 2007	Sa]	isbu	rv. M	aryland
Derit Derit	8	21. Signat	ure of Pun	eral Service l	icensee	1 11			2. Name and				Salis	_			
n saes	8	0	Sori	Ma	B.X	alle	4	J	olley	Memo	orial	Cha		-	•	-	Road 21801
		23a. Part	f. Enter the	disease, or failure. List	complications	that caused	the death. I	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory	arrest,			Approximate
Physici	an	tmmediate	Cause (F		only one-waus	Acu		MY	OCA	RD	1 41	IN	FAR	C	Tinr	1	Interval Between Onset and Death
/Medic		resulting in	r condition n death)		a	un to /or or	2.0000000000	00 061			1770		. , , , ,		110		Hour
Examin	er					H	YPF (	2 TE	NSI	0~							30 46913
	الم الم	Sequentia if any, lead cause. En Cause (Di	Ity list cond ding to imn	ditions, nediate	D. —	ue to (or as	a consequen	ce of):									
cate be executed obysicien and the burial-transit	Examine	Cause (Di	ezneve be		C.												
en ar	Ä	resulting in	n death) La	ıst		ue to (or as	a consequen	ce of):									
ate be ex ohysicien the burial	dicai			10	d												
OX OG / OU, Certificate be executed ading physicien and se as the burial-transit	20	IF FEMAL	E:	_	1												
veguines that the death certific been signed by the attending p should be detached for use as	Physician/Med	23b. Was	decedent p		23c. If y	es, outcome Live birth	of pregnancy 2 Fetal de		Ectopic pre	onancy						te of delive	•
death be atten	2	1 🗆 Y	past 12 m	No	4		time of death		Other (spe						Mo	onth	Day Year
The law requires that the tite has been signed by the rage 2 should be detached.	کام	9 🗆 .	Jnknown		l												
es the grand	3	Parcii. Otti	er signific	ant condition HORF	ns contribution	ig to death bi	ut not resultin	ig in the u	nderlying ca	use give	n in Part I.						e cause of death?
w requir been si should	P		( )	7014	1010	/ 11	ORIT		MEN	1291	/ч ,		10	Yes	2 🗆 No	3 Proba	ably 4 Unknown
VII.d. necolus, lician: The law requires t certificate has been signe rector, page 2 should be o	pie												24a. Wa:		24b.	Were autor	sy findings available
The The Ite ha	Completed													ormed?		death?	pletion of cause of
an: riffica	9	25. Was ca	ase referre	d to medical							26 Place	of Death	Check only		0	1 ∐ Yes	2 L No
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r Attending Phy or death.	- 2				28a.	Oate of Injur (Month, Day		b. Time of		c. Injury	at	2	8d. Describe	how int	ury occur	red	/
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20		n	1. SH	IRAZ	1, M.	D. 3	31575	WI	HTER	2 PE	-A CE	9	MD	2	18	04	,
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AMEND ITEM#29d, perPHYS., G865, 3/2/07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year RAYMOND WARD GARRETT FEBRUARY 17,2007 4:50 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 17586 GRAYSON ROAD ST. INIGOES MARY'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) XXM 2 F 063-18-2881 FEB.12,1925 NEW YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MARYLAND ST. MARY'S ST. INIGOES 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17586 GRAYSON ROAD 20684 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1943-1946 1 ☐ Yes XXNo Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12 MECHANICAL PRODUCTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RAYMOND W. GARRETT EVELYN ANNE RODDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17586 GRAYSON ROAD, ST. INIGOES, MD 20684 HOLLY MOWRER-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) M METROPOLITIAN CREMATORY 2-19-07 ALEXANDRIA, VA 21. Signature of Foheral Service Licensee MO 92 7 9 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Yenal (el) 2005 Due to (or as a consequence of): Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ovonan Diseaso 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 20 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide

**Physician** /Medical Examiner **burial-transit** Hospital or Attending Physicien: The law requires that the death certificate be use as the Division of Vital Records, P.O. this After death. nours after death.
neral Director: A To the Hospital e within 24 hours at To the Funeral D completely

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

Iteme 23a or 28a-1 ahow

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Testifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/19/07 136206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. J. BEAN MEDICAL CENTER MEGITA.

KIRAN 31. Date filed (Month, Day, Year)

MAR 0 2 2007

82. Registrar's Signature 100

Hollywood MDZ0636

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ZOO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, 20-16-42) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 F Days 28 1929 Maryland Feb Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "neturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at TY Yes 2 □ No Maryland Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 Obery Ct. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) 11th 0 Food Service Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 ie marke other traumatic 2 Edward Gross Ethel Harried 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Larkins(Daughter) 130 Hearne Rd. Apt 511 Annapolis, Md. 21401 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State Place of Disposition (Name of Ben Bery Grantatery or other place) Date 20c. Location - City or Town, State permit. Page Depertment of Important: ff any injury or once. Memorial Park 2-19-07 Annapolis, Md. 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Windame Redese of & colisions Mortuary, P.A. 821 West St. Annapolis, Md. 21401 B. Keese MOS 483 Larry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician nears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physicien end use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Voar 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f o 9 Unknown of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Party Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No 2 No Hospital or Attending Physician: ours after death. Ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 F/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide 1 Tertifying Physician: To the best of my knowledge death accurred at the time, date and place. Indiduct, the causu(s) and may not as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Merr) 23a) (Type, Print) Kensyon Rd Hyattsuille MD22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2007 FEB Registrar

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	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Wedical Exercities must be notified at	Funeral Director	10e. Street and Number 12728 Valley	View	Avenue			10f. Zip		1505				of What Cou	untry?	
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		State of Maryland / Department				06152
	1	- State Amended 10%. per &h CCHD Ce	rtificate of Death 2-2		No	00902
Physician		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Medica	1	Robert William Harrison  ia. Facility Name (II not institution, give street and number)	4b. City, Town, or Location of Deat	February	4c. County of Death	10:19 AM
Examine		Memorial Hospital	Easton		Tallot	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yes		place (State or Foreign
Director		212-40-9631 12M 2□F 64 Yrs.	Worth's Days Flodis William	July 2, 1	1942 Mary	land
and	- 1-	Usual Residence of Decedent   10b. County   10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryl f eho	5	Maryland Caroline Hill	Shoro			1 □Yes 2 ☑ No
th with the Marylan 23s or 28s-f show at the notified at	2	10e. Street and Number	10f. Zip Code 21641	10g.	Citizen of What Cou	intry?
death with the Maryland me 23a or 28a-f ehow reast be notified at		11302 Ridgely Road	-21660 - 21041	llne	ited State	es of America
		Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
, o a		1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	ioatian
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d Men d Men marks natic	2	Joseph Price Harrison, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	ng Address (Street and Number or Ru			in Codel
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permit. Pages 1 and 2 should be filed within 72 hc Deperment of Health and Mental Hygiene. Important: If Item 27 le marked other than "natur any figury or other traumatic event, the Madical 2003.		21. Signature of Funeral Service Licensing 2	Name and Address of Facility,	2, P.A.		
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		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		-		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ic Coronary A	tery Ost	ase	9 years
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o the	S C	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
F 5 F 0		Mangen Cross 10th	751439		2-20-8	77
	-	30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)	·	× 000	
		Karen Moffett, M.D., 609 Daffin Lan	e, Denton, Maryla	nd 21629		
State Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	freel B			

		1 - For State Registrer  1. Decedent's Name (First, Middle, Las	State of Maryla		artment o	f Health and of Death	•	Reg. No 0	3. Time of Death
Physic /Med Exami	cal	4a. Facility Name (If not institution, give SALISBURY REHAB	& NURSING (		SAL	n, or Location of De	Feb; ath D. 21804	14, 200 4c. County	Year 07 12:55P
Funeral Director		Usual Residence of Decedent	XIM 2□F 75	: last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Bir (Month, Da 7 – 24 – 1		9. Birthplace (State or Foreig Country) Maryland
Dalitiniofe, Interviewing ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Modical Examinar must be notified at 2008.	Completed by Funeral Director	10a. State 10b. County  MD Wicomic  10e. Street and Number  1514 Riverside Dr  11. Marital Status  1□ Never Married 2☆ Married  3□ Widowed 4□ Divorced  15. Decedent's Ed. (Specify only highest grace  Elementary/Secondary (0-12)	O S  • , A316  12. Was Decedent Ever in tamed Forces? 1 ⊠ Yes 2 □ No1 94 If Yes, Give Year or Dates: 195	9- 52	10f. Zip Coc 218  Vas Decedent C Yes, specify C	01 of Hispanic Origin? Juban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	10g. Citizen of W  USA  14. Race Black Specify:  16b. Kind of Bus	e-American Indian, k, White, etc. White
INCLYICAL A. I. I. I. I. I. I. I. I. I. I. I. I. I.	To Be Cor	6 17. Father's Name (First, Middle, Last) George William Ha: 19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailin	g Address (Str	Pearl eet and Number or	ame (First, Middle, Elizabeth Rural Route Numbe	Maiden Sumame 1 Graft er, City or Town, S	State, Zip Code)
mit. Pages 1 and partment of Health portant: If item 27 y injury or other tr		Frances D. Hann –  20a. Method of Disposition  1 \( \mathbb{M}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{F}\)  4 \( \mathbb{D}\) Donation 5 \( \mathbb{O}\) Other (Specify)  21. Signature of Funeral Service Licens	Removal from State Sp	Place of Dispos cemetery, crem ringhil	sition (Name of natory or other)	ry Gd\$ 2	316, Sal Date -19-2007 Bounds Fu	Hebron	City or Town, State
ate be executed /Medical Examiner the burial-fransit	edicai Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only of shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a)	uence of):	05 E. Nor the mode of a	Main Stre	et Salis	hury. MI	
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	eldeath 3 □l	Ectopic pregna Other <i>(specify)</i>			23d. Date Mont	of delivery h Day Year
quires than signed and be de	ρ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the un	derlying cause	given in Part I.			oute to the cause of death?    Probably 4   Unknown
The lay ate has page 2	e Completed	25. Was case referred to medical				00 Pl4 P	24a. Was a autop perfor	sy pri med? de 2 ₩ No 1 [	ere autopsy findings available or to completion of cause of ath? Yes 2 No
ding Phyen. Ater this funeral dir	ertification: To B	examiner?	lospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 28a. Date of Injury : At he building, etc. (Specification)	28b. Time of Injury	28c. In W	other: 4 A Mursing jury at fork?  Yes 2 No		ence 6 Other	
To the Hospital or Attent within 24 hours after death To the Funerel Director:  completely filled in by the	Medical Ce	29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who co WILLIAM ROBINS, M		n 23a) (Type, P	29c. Lice	opinion, death occurse number	urred at the time, d	ate and place, an	ner as stated. d due to the cause(s)  (Month, Day, Year)
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		DEPTHE	OKI, FID.	21004		

DHMH 17 Rev 1/2001

			For State		State o	f Marylar		artment of I		and Mental I	Hygien Reg. N	7 11 11 1	06454
			Registrar  1. Decedent's Name	(First, Middle, L	.ast)			imouto of		2. Date o	f Death		3. Time of Death
	Physici /Medic		Mary	E.	Hall					Febru	vary	ay Year 200	7 10:37 AM
	Examin		4a. Facility Name (If					4b. City, Town,		of Death		c. County of Dea	
			Salisbu		ab and			Salis If Under 1 Year			Rinth	Wicon	
	Funeral Director		5. Social Security Nu 221-24-3		Sex 1□M 2X1F	7. Age (In yrs. 99	Yrs.	Months Days		Min. (Month	, Day, Year 5/190	7) Del	thplace (State or Foreign ountry) aware
			Usual Residence of	Decedent				1			.5/ 150	,, DCI	
	arylan show	7	10a. State	Wicomi	iao		ity, Town or Lo lisbur						10d. Inside City Limits 1 X Yes 2 ☐ No
	ith the Marylan or 28a-f show	ectc	Maryland  10e. Street and Num			- Da	TIBOUL	10f. Zip Code			10g. C	itizen of What Co	ountry?
	30 or	by Funeral Director	200 Civ					2180	04			USA	
	death	nera	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Original	gin? (Specify Yes o	r No-	14. Race - Ame Black, Whi	
36	or ite	yFu		ed 2 Married	1 ☐ Yes If Yes, Gir	2 <b>X</b> No ve	1	1 ☐ Yes 2XX No				Specify: wh	
Ö	hours furel'	ed b	3 X Widowed	15. Decedent's	Year or D	vates:	16a. Dece	dent's Usual Occu	pation		16b.	Kind of Business	/Industry
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21	giene grtha t, the	Com	11				man	ager	1			etail	
pug	be file	Be	17. Father's Name (		st)					r's Name <i>(First, Mic</i> tie J. Kn			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In Mental Hygiene in marked other than "naturel", or items 23e or 28e-f show umetic event, It a Madical Examinar must be notified at	2	19a. Informant's Na		(Type, Print)		19b. Maili	ng Address (Stree	1	or or Rural Route No			Zip Code)
S	nd 2 saith ar 27 is r treu		Joyce E.				17	Cummings	Court	, Wilming	ton,	DE 1980	4
re,	ss 1 a of Head		20a. Method of Disp		☐Removal from	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. l	Location - City or	Town, State
Ë	Page ment ent: If ury o		° 4 □ Donation	5 Other (Spec	cify)	Sa		y Cremato		2/15/07		lisbury	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other treumatic event, the Madical Examinar must be nutified at once.		21. Signature of Fu	neral Service Lic	ensee	CATP	2	Holloway 501 Snow	Funer Hill	al Home F Rd., Sali	rofes sbury	sional , , MD 21	Association 804
	à.		23a. Part1. Enter the shock, or hear	ne disease, or co nt failure. List on	mplications that of	caused the dea	th. Do not en	ter the mode of dy	ing, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause ( disease or condition resulting in death)		a fa	1-Ka	-70h	1 2	Dere	00			9201-
	/Medical Examiner		resulting in death)	- 1	Que to	(or as a conse	quence of):	0.	1/2	0.	0	/	
		ler	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	nditions, imediate	b. Due to	(or as a conse	quence of):	707	or / Cela		- 4	072	90000
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Ő,	ate be executed hysician and the burial-transi	i Ex	resulting in death) L	ast	Due to	(or as a conse	quence of):						
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ord	requi	eted				<u> </u>					-		
Rec	has t	Completed								а	Vas an utopsy erformed?	prior to death?	utopsy findings available completion of cause of
a	in: The	e Co	25. Was case refer	red to medical					26 Place	of Death (Check or		6 1  Yes	2 □ No
Ž	ysicie is cert direct	0 B	examiner?		Hospital: 1 🗆	Inpatient 2	] ER/Outpatie	nt 3 DOA Ot	hor	rsing Home 5 5		6 ☐Other (Spe	ecify)
0	ng Ph fter th neral	on: T	27. Manner of Death	h 5 🗆 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	Wo			ibe how inju	ury occurred	
sio	death. ctor: A y the fu	catle	2 Accident	investigat	ho	of later Akk			]Yes 2 🗍		n /Street e	and Mumbas as D	ural Route Number,
Division of Vital Records,	or At after d Direct in by	ertifi	4 Homicide	determine	288. Place	ing, etc. (Spec	ify)	reet, factory, office		City or	Town, Sta	te)	urai Aoute Number,
	spitel	al C	29a. Certifier							d place, and due to			
	To the Hospitel or Attending Physicien: The law requires that the death cert within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical Certification:	(Check only one)	2 Medical Ex		asis of examin iner stated.	ation and/or in	vestigation, in my	opinion, deal	th occurred at the ti			, ,
	To the To the Complex of the Complex	Σ	29b. Signature and	title of certifier	11/			29c. Licen	se number	7 08	29d. D	ate signed (Mont	th, Day, Year)
	Ox		1/2	11	Then				2)	19/	17	17/0	7
	20		30. Name and addre	ess of person wh	no completed caus	se of death (Ite	m 23a) (Туре,	Print)	. 1	1.0 50	1:1	I W	1 1 1 1 1 NII
	()Sta	ite	31. Date filed (Mont			Registrar's Sign	nature	UU CIV	C- /4	ve, sh	11361	nry //	VI LIONY
	Regist			FEB 16	2007	geere .	H.	book					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 06455 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEB.  $1\overset{\text{Day}}{9}$ , **Physician** Elizabeth Ν. Jones 2007 4:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Denton Caroline Nursing Home Caroline 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1917 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 89 216-07-9203 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28e-1 show with injury or other traumatic event, the Medical Examiner must be putilled at ODGs. Federalsburg 1x√Yes 2 No Caroline MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 United States 201 West Central Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify 2 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel Service Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Artery Nichols Maltina Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 W. Central Ave., Federalsburg, MD 21632 Vickie J. Galloway/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/24/07 Federalsburg, Hillcrest Cemetery 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of) the attanding physiclan e hed for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 No 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate 1 Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) treston 136 2r ednum Nelinda 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Diane Johnson		1- For State Registrar		ate of Maryla		oartment <i>ertificate</i>		nd Ment	al Hygiene	Reg. No.	200	7 06451
Physicia Medical Examir		1. Decedent's Name Diane		<sub>e,Last)</sub> Patricia	Joh	nson			2. Date of Do Month Februar	Day	Year	3. Time of Death 0632 hrs
	ı	4a. Facility Name (if			mber)		4b. City, Town, Salisbury	or Location of		4c	: County of Dea	ath
Funeral Director						s. last birthday)	If Under 1 Your Months Da	ear If Under	Min	Birth (MM/	DD/YYYY) 9. E	
Billottor	-	578-72-23 Usual Residence of		1 M 2 X F	53		Yrs		12/1	5/19	53	Virginia
* any	tor		10b. County		10c. C	ty, Town or Lo	cation					10d Inside City Limits
yland I-f shov		Maryland 10e. Street and Num		mico		Salisbu	10f. Zip Code			10a Citis	zen of What Co	1 X Yes 2 No
the Mar.	Director	233 Ohi					218			USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marrie	d 2 M	arried 12. Was Dec	cedent Ever in orces?				n? ( Specify Yes or I Puerto Rican, etc.)	No-	White, etc.	
s after	ক্র	3 Widowed		orced If Yes, Give Yea or Dates: cify only highest grad	ır	1	Yes 2 X		ind of work done		Specify: \(\frac{1}{2}\) Kind of Busines	white
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and 2 steath a		20a. Method of Disp		ed/friend	20	b. Place of Disp	osition (Name of		lisbury,		L801 Location - City	or Town, State
more bages 1 ent of H nt: If i	١	1 Burial 2 4 Donation 5		n 3 Removal fr	om State	crematory or alisbur	other place) Y Cremat	ory	2/14/07	Sa	alisbur	y, MD
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.	İ	21. Signature of Fur	neral Service	icensee	rsp.	22	HOTTOWAY 501 Snow	Funer Hill	al Home P Rd., Sali	rofes	ssional y, MD 2	Association
Physician /M-gical		23a. Part I. Enter the failure. List onl	e disease, or y one cause	complications that con each line.		ath. Do not ente	er the mode of dyin	ig, such as cai	rdiac or respiratory a	arrest, sho	ck, or heart	Approximate Interval Between Onset and
Examiner	İ	Immediate Cause (For condition resulting		a. Hypertensi			rdiovascular D	isease				Death
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cords, P.O. Box 6876 law requires that the death certificate has been signed by the attending phase been signed by the attending phase is should be detached for use as the	sicia	1 Yes 2 ✓ N		7 -	nant at time of own	death 5	Other (Specify)					
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Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	T:U	27. Manner of Death	h	28a. Date	of Injury Day Year)	28b. Time 0000 hrs	of Injury 28c. Ir	njury at Work? Yes 2 ✔	Subject fe			
Sior Attend r death ector: by the	catic	2 🗸 Accident		stigation Jan.	23, 2007	7	treet, factory, office		Subject 28f Location	(Street a	ed & fel	Rural Route Number, City
Div oital or ours afte	Certification:	3 Suicide 4 Homicide		Id not be (Specify)	Parkir Single F	ng Lot amily Home	treet, factory, office		or Town 233 Ohio A	, State) venue , 8	S. Salis	bury Blvd Salisbury, MD
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1792.		30. Name and addre		who completed cau			nn Street, Bal	timore MF	21201			
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		,	For State	State of I	Maryland / Depa			lental Hy	giene	7 001 57		
			Registrar  1. Decedent's Name (First, Middle	/act)	Ce	rtificate of	Death	eg. No. 2 U U U U U U U U U U U U U U U U U U				
¢ .	Physici /Medi		FRANK B	KORRI	ELL JF	Ł		2. Date of Dea Month FEBRUAR	Day Year			
	Examir		4a. Facility Name (If not institution	, give street and number	er)	4b. City, Town, o	r Location of Death		4c. County of Death			
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₹.	Funeral Director		5. Social Security Number 2 1 6 - 1 4 - 6 4 1 9	Age (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	1	of Birth 9. Birthplace (State or Forei Country)  1 6 - 1 9 2 2 MD				
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has "refer as 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	If Ves Give	TNo	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi			
Q	2 hou atura	ed	15. Decedent	's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business			
21215-0036	within 72 iene. than "na he Medi	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4c	or 5+) (Give	kind of work done DO NOT use retired	during most of work d)	ring				
	filed withi Hygiene. ther than int, the M	Son	7			Sales			Automoto	tive		
Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle,	,				, , ,	Maiden Surname)			
Ş	ould be a montal marked o	ဥ	Frank B. Korn		405 84-10	A dal /04/				th Nusz		
Z	d 2 sho th and 7 Is ma trauma		19a. Informant's Name/Relationsh Evelyn I. Kon						er, City or Town, State,	•		
ā,	tem 2		20a. Method of Disposition	TEIL WI	20b. Place of Dispo			Date Date	20c. Location - City of	k MD 21702 r Town, State		
JO L	Pages ent of nt: If i		1 XBurial 2 □Cremation 4 □ Donation 5 □ Other (S		ite		4	2007	D 1			
Baltimore	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau		21. Signature of Funeral Service		Resthav	2. Name and Addre	ss of Facility Ke	enev &	Rasford	k, Maryland P.A. F.H.		
œ	De au		Jula G.	Ston	M01176 1	06 East	Church	St. F	rederick,	MD 21701		
r			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between		
1	Physician		imm te Cause (Final disease or condition	_a (h)	unic Uss	Truct	14 14	lmina	ry Dijung	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	1	,		7	7-7		
E		<u>-</u>	Sequentially list conditions,	b. Due to (or	as a consequence of):							
P	uted 1 ansit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
, O	exection and and rial-tra	Examiner	resulting in death) Last	Due to (or	as a consequence of):							
58760,	cate be executed physician and the burial-transit	dical		d								
	ertifica ing ph	Med	IF FEMALE:									
Вох	ath ce ttendi or use	an/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	y		23d. Date of de Month	elivery Day Year		
	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9∐Unknowr		Other (specify) _			Monar	Day Foat		
, P.O	that the plant of	됩	Part II. Other significant condition	ns contributing to death	n but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
Records,	quiree n sigr uld be	d by	HUNGTE	2510				) DEC	Çes 2 □ No 3 □ P	robably 4 ☐Unknown		
000	aw requir s been si 2 should l	Completed		·				24a. Was a	an 24b. Were a	utopsy findings available		
æ	The lav	mo						autop perfor 1∐ Yes		completion of cause of s 2 □ No		
Vital	iclan: The certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat		70			
or V	Physician: r this certific ral director,	To	1 ☐ Yes 2 No		atient 2 ER/Outpatier		4   Nursing Ho	ome 5 Resid	ence 6 Other (Spe	ecify)		
n	ding P	:uo	27. Manner of Death  Death  5 ☐ Pending		njury 28b. Time o <i>Day Year)</i> Injury	Wor		28d. Describe h	ow injury occurred			
isio	Attending It death. ector: After by the fune	cati	2 Accident investig	ot be 280 Place of	injury - At home, farm, str		Yes 2□No	28f Location /S	treet and Number or Fi	lural Dauta Number		
Division	lor A after Direct	Certification:	4 ☐ Homicide determi	ned building,	etc. (Specify)	cot, lactory, office		City or Tow	n, State)	urai noule Number,		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		(Check only 2 Medical:	Examiner: On the basis	st of my knowledge, deat s of examination and/or in	h occurred at the til	me, date and place, opinion, death occur	and due to the or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)		
	thin 2 the orthe	Medical	one)  29b. Signature and title of certifier	and manner	stated.	29c. Licens	e number		29d. Date signed (Mon	th Day Year)		
	F > F 8		) land	11	Mi		6428		2.12	5(07		
	¥Ì.		30. Name and address of person	who completed cause of	f death (item 23a) (Type	/ "	V 7 & V		-	3 \ 0		
	101,			line M.D	. 300 West	9th St	. Frede	rick. N	1D 21701			
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	و نی		, ,				
	Regist	ar	MAR 0 2 20	Ul Selection	is the	and the same of th						

		1- State of Maryland / Department of Health a 27,28a-f per me, 865,03/21/07dhb	nd Mental	Hygiene Reg. No.	007 06458
		Decedent's Name (First, Middle, Last)	2. Date of	f Death	3. Time of Death
Physici /Media		Willard Clyde Keifer	Month	Day -14 - 200	Year 13:49M
Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			inty of Death
		Garrett Co. Memorial Hospital Oakland		Garr	ett
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours 7. Age (In yrs. last birthday) Vrs.	Min. (Month	. Dav. Year)	Birthplace (State or Foreign Country)
Director		213 24 6694 Tyrs. Triangle Tri	Feb.	27 1929	)   WV
yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Mar	ctor	WV Mineral Elk Garden			1 □ Yes 2 □ No
ith th or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen	of What Country?
ath w		Rt 1 Box 151 K 26717		USA	
er de Items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes o Puerto Rican, etc.	r No- 14. F	Race - American Indian, Black, White, etc.
J36	by Funeral	1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ NdKorea 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 및 No Specify: 1 □ Yes 2 □ NdKorea 1 □ Yes 2 □		Spe	city: White
ING 21215-UU36 be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or items 23s or 28s-f show event, if a Maylest Examiner must be notified at	ted	15. Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of	Business/Industry
212 Pin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of life. DO NOT use retired)	of working		,
Maritime of with the state of t	Ş	12 US Navy		Milit	arv
Dd file	Be	17. Father's Name (First, Middle, Last)  18. Mother	's Name (First, Mid	ddle, Maiden Sum	ame)
Taryla 2 should and Men Is marke aumatic	은		Martha Na		
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. ?? Is marked other then "natural", or traumatic event, If a Mudical Exami		19a. Informant's Name/Relationship (Type, Print)  Edith Keifer  19b. Mailing Address (Street and Number  Rtl Box 151 K Fl			
Iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, If a Madical Examiner must be notified at		Edith Keifer Rt1 Box 151 K E1  20a. Method of Disposition   20b. Place of Disposition (Name of	LK Garden Date	-	0717
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 Is marked other then any injury or other traumatic event, ILAM, once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		11 10 200-2	n - City or Town, State
it. P. rtme rtent			b 17 07	Bayar	d,WV
Balt permit. Depart Import		1// 1 1/8	Burdock-	Durst FH	
		23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	Oakland ardiac or respirato	MD 21	550 Approximate
Physician		Stycek, or near tailure. List only one cause on each line.  Immediate Cause (Final	,	,	Interval Between Onset and Death
/Medical		disease or condition resulting in death)  a.   ue to (or as a consequence of):			minutes
Examiner		12Cl Isa Cont		111	-1 woods
T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		CAMPE	, week
acuter	Examiner	inat initiated events C.	/	ENC. E	U()
8 / 60, sate be executed shysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	Wholede	No.	
the the	dlcal	d	1. MAPROVEDE		
HECONGS, P.O. BOX 6  The law requires that the death certific tte has been signed by the attending f  age 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	OFICKTON.		
BOX 6 eath certif attending for use as	clan	23b. Was decedent pregnant in the past 12 months?  1	. J		Date of delivery Month Day Year
hat the d	ysl	9 ☐ Unknown 9 ☐ Unknown		_	
that s that need be determined by	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco use co	intribute to the cause of death?
COTGS,  ** requires been sign should be	p p		1	☐Yes 2XNo	3 ☐ Probably 4 ☐ Unknown
as been 2 should	Completed		24a. W		. Were autopsy findings available
The la	E O		_ p	itopsy erformed?	prior to completion of cause of death?
VITAL iclan: 1 certifical ector, p	a	25. Was case referred to medical 26. Place of	1 ☐ Ye		1 Yes 2 No
- S S S	To B	Hospital:	ing Home 5□R		ther (Specify)
On Of ding Phy h. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?		oe how injury occu	
VISION Attending r death. ector: After	cati	2 Accident investigation 02/07/07 Unknown 1 ☐ Yes 2 No	Subje	ct fell	
or At fter d fter d jrect	Certification:	4 Homicide determined determined building, etc. (Specify)	28f. Locatio City or	Town State)	nber or Rural Route Number,
pital urs a arai D	ပ္	home			K.Elk Garden
Hos 24 ho Fun Fun	edical	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)	place, and due to to occurred at the tin	he cause(s) and n ie, date and place	nanner as stated.  o, and due to the cause(s)
DIVISIC DIVIDITION TO the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signator and title of certifier 29c. License number			ned (Month, Day, Year)
F 3 F 8		17 Tally (194) 033454		02/15	
. fix		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		02/13/	2001
AVA	1		26716		
Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	20/10		
	ar	FEB 1 6 2007 Person D. Acerth			

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e Type or Print in Black Indelible Ink. Sure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1- Stata Registrar Amend #8, perFH, g871, 9/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Edward Massey 02 5:12 AM seorge 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1480 Old Telegraph Rd Warwick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, July 17, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F 222-12 - 2205 79 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director MD Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Telegraph Items 23a 1480 21912 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other treumatic avant, the Medical Exertirat ODGs. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 45-46 1 ☐ Yes 2 ☑ No þ Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dover Coca Elementary/Secondary (0-12) College (1-4or 5+) Asst. Manager Bottling Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse William Massey Alva Josephine Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orna L. Massey -1480 Old Telegraph Re, Warwick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2-20-07 Cemetery akeside 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torbert 21. Signature of Funeral Service Licensee Funeral Chape) Stilling overfler Bradford St., Dover De 19904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a and I-transit or Attanding Physician: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death Check only one) examiner? 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A M 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month; Day, Year) 1220 em 23a) (Type, Print) 30. Name and address of person who completed cause of death 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** George Edward Noonan, Jr. M February 13, 9:05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 508 Clyde Ave. Fruitland 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/17/1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 ☐ F Vrs 88 Director 082-05-2040 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other freumatic event, if a Medical Exam are must be confiled as page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Wes 2 ☐ No Director Maryland Wicomico Fruitland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 508 Clyde Ave. 21826 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No Army
If Yes, Give
Year or Dates: WW II 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Highway Commission Equipment Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Edward Noonan, Sr. Ida Mary heim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois S. Noonan/wife 508 Clyde Ave., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory of other place)
Springhill Memory
Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2/15/07 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Holloway Puneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 4 DOMPOOD CEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a section. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 0 /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due te-for as a consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed ig physicien and as the burial-transit ovenav 2 V Due to (or as a consequence of): Box 68760. IF FEMALE: 950 . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown been signed to should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy performed? Yes 2 No 1 Yes the Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 N 2 ER/Outpatient 3 DOA this 27. Manner of ath 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 124 hours etter de Te Funerel Directo pletely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed sause of death (Item 23a) (Type, Print) Md. 05 Fe Ho

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Registrar

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Year

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31. Date filed (Month, Day,

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene' 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month Feb. Year **Physician** 25, Joseph Homer Pellerzi 6:52 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 11 Richard Wav LaVale If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth

(Month Day Year)

Jun 1, 1927 **Funeral** Days Hours 1 € M 2 □ F 220-16-6941 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Macdical Expander must be notified at Allegany LaVale MD 1√1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11 Richard Way 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No If Yes, Give Year or Dates: 1946-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Hygiene. Elementary/Secondary (0-12) Allegany Co Bd of Ed. assistant superintendent ges 1 and 2 should be filed t of Health and Mental Hygi If tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lda Lezzer Pellerzi John Pellerzi 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Yorktown Place Charleston WV 25309 19a. Informant's Name/Relationship (Type, Print) daughter Ruth Hopkins 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Injury or 3/1/2007 Rocky Gap Veterans Cemetery Flintstone MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mce1 disease or condition resulting in death) ZZ mouth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 @Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 26,200 D17526 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John N. Mehanna, M.D.; 904 Seton Dr Suite 205; Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 2 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** February 11, 2007 11:40  $A^{M}$ V. /Medical Martha Prvor 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9583 Opossumtown Pike Frederick Frederick 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan. 15, 1 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛛 F 75 <del>202</del>-26-5006 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a, State 10b. County Frederick Frederick 1 ☐ Yes 2 ☑ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21702 permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a c any Injury or other traumatic event, the Medical Examiner must b once. 9583 Opossumtown Pike by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Summers Oscar Fisher ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20810 Netz Rd., Boonesboro, MD 21713 19a. Informant's Name/Relationship (Type. Print) Janet Rhinecker / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Entombment Resthaven Memorial 2/15/2007 Frederick, Maryland 21. Signare of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702

mode of dying, such as cardiac or respiratory arrest,
Interval Between Onset and Death a 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cards on each line. dome Immediate Cause (Final Physician years disease or condition resulting in death) /Medical Due to (or as e consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ate has page 2 s autopsy 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of Yo the nospose within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funer of the funer of the funeral of 28c. Injury at 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12,2007 866 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B TJ Drive, Frederick, MD 21702 Kanan Hudhud, MD 46 31. Date filed (Month, Day, 2ea) 32. Registrar's Signature State 2007 Registrar

AndRew Rucci Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		- FOI	tment of Health and Mental Historicate of Death	
Physicia	an	1. Decedent's Name (First, Middle, Last)  Andrew Anthony Rucci.	2. Date of Month	f Death Day Year  3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)  Civista Medical Center	Ab. City, Town, or Location of Death  La Plata  If Under 1 Year   If Under 24 Hrs.   8, Date of	/4c. County of Death Charles
Funeral Director			Months Days Hours Min. December	r 18,1940 New York
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		10e. Street and Number 13930 River Road	10f. Zip Code 20664	10g. Citizen of What Country? USA
ırs after deatt ıl", or items 2 :xaminer mus	by Funera	1 Never Married 2 Married 1 Tyes 2 No	as Decedent of Hispanic Origin? (Specify Yes or es, specify Cuban, Mexican, Puerto Rican, etc. Yes 2 No Specify:	or No- 14. Race - American Indian, Black, White, etc.  Specify: White
hin 72 hou e. <b>an "natura</b> Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	nt's Usual Occupation nd of work done during most of working o NOT use retired)	16b. Kind of Business/Industry
be filed wit ttal Hygien td other that event, the	Be	12 Re  17. Father's Name (First, Middle, Last) Savino Rucci	staurateur  18. Mother's Name (First, Mic Nicoletta Ru	•
2 should and Men 'is marke	은	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing A	Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
Pages 1 and nent of Health int: if item 27 iry or other tr		Carole Rucci/Wife 13930  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (SpecifyEntombment Resurrect)	1	20c. Location - City or Town, State
permit. Departm Importa any Inju		21. Signature Funeral Service Licensee M00945 22A.	REHART ECHOLIS FUNERAL 11 St. Mary's Ave. La	HOME,P.A. Plata,MD 20646
Physician /Medical		23a. Part . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	the mode of dying, such as cardiac or respirato	Approximate Interval Between Onset and Death 45 minutes
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Cardiac  Due to (or as a consequence of):  Coronary  Due to (or as a consequence of):	ischemia artery disease	e 20 years
The law requires that the death certifical attending phy atte been signed by the attending phy agge 2 should be detached for use as the			ctopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the under INSULIA DEAT DIAL	1	Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
	Completed	Hypertension	a	Was an autopsy autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2  No		nly one)  Residence 6 □Other (Specify)  ribe how injury occurred
oital or Atteurs after de sral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	City or	on (Street and Number or Rural Route Number, r Town, State)
the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.  29b. Signature and title of certifier	occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. lime, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
J. W. D.				
1612 Sta	ata.	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	D37874 int) Medical Staff (South PORt DR. Mo	golvices orrisville NiC. 27560
Registr		FEB 1 6 2007 Steen & Som	pade.	d/360

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 920 M **Physician** Helen Μ. Russell FEBRUARY 14 2007 /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPITAL MEMORTAL ASTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 k F 77 222-16-8699 Nov. 10, 1929 Delaware Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No MD Caroline Federalsburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 6100 Todd Road 21632 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 ☐ Yes 2X No White 21215-0036 Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be William Melunev Effie Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan D. Russell/Daughter 636 Lomax St., Easton, 21601 MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Concord Cemetery 02/19/07 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Eskow 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MILKYO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 res 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1. Inpatient Certification: To After this 27. Manne Leath 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. (Month, Day 5 Pending investigation 1 Anatural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi 50 LUCWIG 32. Registrar's Signature 31. Date filed (Month Day, State

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 09 Antonio Rodriquez Jr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENIASURA REGIONIDA MEDIRAL centa SALISBUIL NICOMIC 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 □ F Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TXYes 2 □ No Director Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10136 Georgetown Road 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: African American Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Puerto Rican Puerto Rican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marco Antonio Rodriquez Tasha Erica Brittingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tasha Brittingham/mother 10136 Georgetown Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Salisbury Crematory 2/15/07 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Service (ic) nsee 24/31130/440\*Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Heite K 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician F. Tomme /Medical Due to (or as a consequence of): Examiner HORIS ANVISE, Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran-Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use co ibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 v o 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed within 24 hours after death. To the Funeral Director: After this certificate 1☐ Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 30H00 1 Thpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. To the § 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar BRUCE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

100 E. Carroll

152

VIVBUR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16

NNHESSI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 05467
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Registrar		C	ertificate d	or Deal	m			F	leg. No.			
Physici	an/	n/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year									Time of Death			
∕ledical Exami		Anthony R. S												
		4a Facility Name (if not institution Route 70 West of Route 70 West of Route R		4b. City, Town, or Location of Death  Hagerstown					4c. County of Death  Washington					
	-	Social Security Number	6. Sex	7 Age (In w	s. last birthday)		ler 1 Year	If Under:	24Hrs 8	R Date of Ri				lace (State or
Funeral Director		· · · · · · · · · · · · · · · · · · ·				Month		Hours	Mun			F	oreign	
Director	l	210-60-1571	1XXM 2 F		.6 Y	rs.				pec.	19, 19	80	Count	ry) PA
ž.	}	Usual Residence of Decedent  10a. State 10b. County		1100 0	city, Town or Loc	ation							11/	0d Inside City Limits
w ar			-1-1:	100. 0										XX Yes 2 No
Maryland 28a-f show any datonce,	ğ		nklin		Greenc					The second second				
Man r 28a ed at	Director	10e. Street and Number				10f. Zip				10g. Citizen of What Country?				· ·
with the Maryland ns 23a or 28a-f sho be notified at once,		659 Lohman A					7225				USA			
<b>21215-0036</b> Uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f sho e event, the Medical Examiner must be notified at once	Funeral	<ul> <li>11. Marital Status</li> <li>1 X Never Married 2 M</li> </ul>	12. Was De Armed F		If		ent of Hispa ify Cuban, I			ify Yes or No can, etc.)		White, e		n Indian, Black,
r dea or it	교		1 Yes	2 X N	1	7 v 6	XX No						ـ د د ما-	
hours afte 'natural", Examin <u>e</u> r	Ď	3 Widowed 4 Div	or Dates:						nd of worl	k done	16b. Kind	of Busin		
hour 'nate	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)			orking life. D					lula		,
-0036   within 72 giene her than "	립				data	spec	ialis	st			tel	epho	ne	co.
5-00 iled with Hygien I other	ρ	17. Father's Name (First, Middle					18	8.Mother's	Name (F	irst, Middle,	Maiden Suri	name)		
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	Be (	Daniel J. Si	monetti,	Sr.				Rosa	lind	Kern	lsky			
21215 buld be fill Mental H marked	2	19a. Informant's Name/Relations			19b. Maili	ng Addres					Town, State, Zip Code)		p Code)	
MD d2 shc ulth and m 27 is aumati		Rosalind Simo	netti n	nother	659	Lohm	an Av	renue	Gree	encast	le, P	A 17	225	2
e, e, land land Healt item		20a. Method of Disposition	-₩	20	b. Place of Disport			etery,	D	ate	20c. Loca	ation - Cit	ty or To	wn, State
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		1 X Burial 2 Cremation 4 Donation 5 Other St			edar Hi	•		-v/	2/26	/2007	Gree	ກດຂຣ	+10	РΔ
nit. Partme		4 Donation 5 Other Si 21. Signature of Funeral Service					d Address of							al Home
Balt permit. Departi Import		James Q. Barrel	OSLEW		15	21 So	uth W	Jashii						le PA 1722
Physician		23d. Part I. Enter the disease, or	r complications that	caused the de	ath. Do not enter	the mode	of dying, s	uch as car	diac or re	spiratory ar	rest, shock,	or heart		Approximate Interval Between Onset and
Hyledical		failure. List only one cause Immediate Cause (Final disease	ورينوا امرمال	ries									1	Death
Examiner		or condition resulting in death)		a consequenc	ce of):									
	l , l	Sequentially list conditions,	b										_	
	ine	if any, leading to immediate cause. Enter Underlying Cause		a consequenc	ce of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last		a consequenc	ce of):									
8760, tificate be executed ing physician and as the burial - transit			d											
e exe	Physician/Medical	UNPENDED	AMENDED	•										
8760, tificate bung physic as the bun	₩ We	IF FEMALE: 23b. Was decedent pregnant in the	L	, outcome of p				7				ate of de		
as as		past 12 months?	Dros	birth gnant at time o	f doath	etal death		Ectopic p	pregnancy	У	Moi	nth	Day	Year
Box e death of the atten	/sic	1 Yes 2 No 9 Un			r death 5	Other (Spe	ecify)				100			
P.O. Box 68 s that the death certing and by the attending e detached for use a	P,	Part II. Other significant condit	tions contributing	to death but n	ot resulting in the	underlyin	g cause giv	ven in Part	I.	23e. Did	obacco use	contribut	te to the	cause of death?
P.O.	<u>ھ</u>									1 Y	s 2 🗸 No	3 🗌	Probab	ly 4 Unknown
ords, w require is been si should b	Completed				<del></del>					24a. Was				sy findings available
SOF Jaw ra has b	힐									auto perfe	psy ormed?	prio dea		pletion of cause of
tal Recian: The certificate	ပ္ပ									1 Yes	2 No	1 🗸	Yes	2 No
tal Rec cian: The l certificate	Be	25. Was case referred to medical examiner?	Hospital:				26.Place o	Yhor			1		211 0	
'Yysi hysi al dir	ဥ	1 Yes 2 No		Inpatient 2	ER/Outpatie		DOA 28c. Injury		Nursing h		Residence how injury of		otner: 5	cene
n of \ding Phy.  After the funeral	ä	27. Manner of Death  1 Natural 5 Pen	nding Feb 22	te of Injury hth, Day Year) 2, 2007	0058 hrs	n injury		es 2 🗸 N	lDr		fixed obj		lision	
Sior Vitenc death ctor:	cati		estigation		14 h a a a	and feeter			_	of Longtion	Street and I	Mumbor c	or Dural	Route Number, City
Division of Vital Records, tal or Attending Physician: The law requiring a fare death.  The law requiring the remaining the fare factor, page 2 should to be the funeral director, page 2 should the fare fare fare fare fare fare fare far	Certification:		ald not be		At home, farm, st		у, опісе ви	iliaing, etc.		or Town.				
Division  Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the		4 Homicide	(0)0000		oad / Highwa									WII, IVID
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. The the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	edical	(Check only Certifying F	Physician: To the beaminer: On the basis	est of my know s of examination	vledge, death occ on and/or investig	curred at th gation, in m	ne time, dat ny opinion,	e and plac death occu	e, and du urred at th	ie to the cau ne time, date	se(s) and m and place,	anner as and due	to the c	ause(s)
To the within To the comple	Med	29b. Signature and title of certifi	and manner				c. License							, Day, Year)
	-	n +A					O.C.N				Februa	_		•
		Handley Buth	Well, MA		Itam 22-1							,,		
10		30. Name and address of person Pamela E. Southall, M		t Medical E		I11 Peni	n Street,	Baltimo	ore, MD	21201				
	le de		<u> </u>	Registrar's Sig	- 4									
Regis	tate	31. Date filed (Month, Day, Year)	2007	Ester L	nature	8								

		1 - For State Registrar	State of Maryland /			of Healt of Dea			giene Reg. No.		06468
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Josephine Ber	tha Somody				9-	2. Date of Dea Month	Day		3. Time of Death
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	own, or Locati	ion of Death			County of Death	
	П	Citizens Nursin	3 Home		Hay	Te De	Grace			Harford	
Funeral Director		5. Social Security Number 6. Sex.  043-03-7380	7. Age (In yrs. last b	Yrs.	If Under 1 Months	Days Hou	rs Min.	8. Date of Birth (Month., Day 7/31/19	12"	9. Birth Coul New	place (State or Foreign http:) York
Maryland f show	or	10a. State 10b. County MD Harford	10c. City, To Aber								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the a or 28a-	Director	10e. Street and Number 500 Beards Hill Ro	nad.		10f. Zip (	21001			-	zen of What Cou	ntry?
death	Funerai		2. Was Decedent Ever in U.S.	13.	Was Decede		: Origin? (Spec tican, Puerto R	ify Yes or No-		14. Race - Ameri	can Indian,
15-UU36 72 hours after death with the Marylan "natural", or Hems 23a or 28a-f show "natural", or Hems 23a or 28a-f show salical Era nitet must be notified at	by	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, specii 1□ Yes 2			lican, etc.)		Black, White, Specify: Wh	etc. ite
ING 21213-UU36  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, I'm Medical Exercites must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give		Occupation done during in retired)	most of working	g		nd of Business/In	dustry
nd 27		O (Circle Middle / cot)		HOME	maker	10.14	lathada Nama	/Firm & & & district		home	
ed als be	To Be	17. Father's Name (First, Middle, Last)  Edward Brix  Bertha Dostal									
		19a. Informant's Name/Relationship (Type Edward V. Somody	(Son)	500	Beard	s Hill	Rd., A	berdeer	ı, M		
Page Page ment a		20a. Method of Disposition  1 ☐ Burial 2X Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	tery, crei	osition (Name matory or oth Cris &	ner place)	2/27/			cation - City or To Chester	
Baltim permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	s Une less	2	Tarrii Aberde	Address of Fang-Card	o Fune: Trylnad	ral Hon 21001	ne, ] -339	P.A. 99	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications, content failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. De cause on each line.  Metaltali  Due to (or as a consequence	- (j.	L		as cardiac or		rest,	2	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
58760, & crate be executed physician and sthe burial-transit	dicai	resulting in death) Last	Due to (or as a consequenc	e of):							
Records, P.O. Box 68760, Company for the law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	Bc. If yes, outcome of pregnancy 1		⊒Ectopic pre ⊒ Other (spe				2	23d. Date of deliv Month	ery Day Year
dS, P. uires that I signed by Id be deta	by	Part II. Other significant conditions con	tributing to death but not resulting	j in the u	ınderlying ca	use given in P	art I.	23e. Did to		1	he cause of death?
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be control.	Completed							24a. Was a autop perfor	sy	24b. Were auto prior to co death?	opsy findings available empletion of cause of
	မ င်	25. Was case referred to medical						1 Yes	2 <b>X</b> No	1 🗆 Yes	2 No
	o B	eyaminer?	ospital: 1 ☐ Inpatient 2 ☐ ER/0	Outnatie	nt 3 DO		Nursing Hom			6 □Other (Specia	6.1
Vision of Vita Attending Physician: r death. actor: After this cartific by the funeral director,	<b> -</b>	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		. Time o		ic. Injury at Work?	21	8d. Describe h			y)
in Light of Line	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, st	reet, factory,	office	21	8f. Location (S City or Tow		d Number or Rura )	al Route Number,
To the Hospital or within 24 hours after To the Funeral Direction completely filled in the filled in	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowled ter: On the basis of examination and manner stated.	ige, deat and/or in	th occurred anvestigation,	t the time, dat in my opinion,	e and place, ar death occurre	nd due to the o	ause(s) date and	and manner as s I place, and due to	stated. o the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier.	n. MD		29c.	License numb	609		29d. Dat	e signed (Month,	Day, Year)
		30. Name and address of person who co		a) (Type,	Print)	Trans	+ Har	rede	Goz	ace Ms	7 21078
Sta	ate	31. Date filed (Month, Day, Year)	82. Registrar's Signature	A STATE OF THE STA							3

Registrar

MAR 0 2 2007

07-01167 **Duwayne Thomas** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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20	UI	Ub	46

		1- For State Registrar	ertificate of Death	Reg. No.	1 0040
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	3. Time of Death
edical Exami	ner	DU WAYNE ANTHONY THOMAS	4b. City, Town, or Location of Death	February 11, 2007	2147 hrs
		4a. Raciji Name (if not institution, give street and number)	Bryans Road	Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)  If Under 1 Year If Under 24Hrs  Months Days Hours Min	8. Date of 8irth(MM/DD/YYYY) 9. 8	rthplace (State or gn WASHINGTON,
Director		577-94-6719 1XM 2 F 30	Yrs	APRIL 7, 1976	ountry) D.C.
tuy		Usual Residence of Decedent         10a. State         10b. County         10c. Cit	y, Town or Location		10d. Inside City Limits
nd how s	_	MARYLAND CHARLES BR	YANS ROAD		1 X Yes 2 No
ne Maryland or 28a-f show any fie <u>d at once.</u>	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	untry?
72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho al Examiner must be notified at once.		6612 BUCKNELL ROAD	20616	UNITED STAT	ES
th with	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (S		rican Indian, Black,
er dea		1 Yes 2 X No	1 Yes 2 X No specify:	Specify: BI	.ACK
urs aft tural'	d b	or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of	work done 16b. Kind of Business	
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret		
5-0036 led within Hygiene other tha the Medic	Completed	12TH GRADE	SALES ASSOCIATE	RETAIL	
15-( filed of Hygied of Hygied of the	Be Co	17. Father's Name (First, Middle, Last) WILLIAM THOMAS		e (First, Middle, Maiden Surname) POSEY-THOMAS	
212 uld be Mentz mark	0.	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or		e, Zip Code)
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene, n 27 is marked other than unmatic event, the Medica		WILLIAM THOMAS / FATHER	6612 BUCKNELL ROAD, B	RYANS ROAD, MARYLA	ND 20616
		1 X Purial 2 Cramation 3 Pamayal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City o	
Pages nent o ant: I or oth		4 Donation 5 Other Specify:	ASANT GROVE CHURCH CEMETERY F		
Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr		21 Signature of Fernaral Service Licensee  LYDIA C. THORNION JOHNSON 100583	22. Name and Address of Facility THO 3439 LIVINGSTON RO	ORNTON FUNERAL HOM	E, P.A. MARYLAND 2064
Physician		23a. Part I. Enter the disease, or complications that caused the dear		-	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Contact Gunshot Wou	ind of Head		8etween Onset and Death
Lammer		or condition resulting in death)  Due to (or as a consequence	of):		
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence	of):		<u> </u>
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence	of):		
ecuted and transit		events resulting in death) Last Due to (or as a consequence d.	o.,.		
e ex	Medical	UNPENDED X AMENDED DETME, S	2865, 3/17/07 TT		
760, icate be ex physician the burial		IF FEMALE: 23c. If yes, outcome of pre	gnancy	23d. Date of delive	•
Sox 687 leath certific e attending	cian	past 12 months? 1 Live birth Pregnant at time of the past 12 months?		ancy Month	Day Year
Box e death c the atten ed for us	Physician	1 Yes 2 No 9 Unknown g Unknown			
Records, P.O. Box 68' The law requires that the death certific care has been signed by the attending page 2 should be detached for use as it.	by P	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to  1  Yes 2 ✓ No 3 Pro	
rds, F requires been sign should be					utopsy findings available
Records, The law require ficate has been si	Completed			performed? death?	completion of cause of
	ပ္ပ	25. Was case referred to medical	26.Place of Death (Check		es 2 No
<b>/ital</b> sician is cert lirecto	Be	examiner? Hospital: 1 Innationt 2	Other	ng Home 5 Residence 6 🗸 Othe	er: Scene
of Vital ing Physician: After this certif uneral director	٦. ا	1 ✓ Yes 2 No I III III III III III III III III II	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion tendin eath tor: A	atio	1 Natural 5 Pending PoUND: Peb 11, 2007	FOUND: 1 Yes 2 No No	Subject shot self	
Division of Vital I To the Hospital or Attending Physician: within 24 Hosons after death To the Funeral Intector: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) 2216 Bucknell Road, Bryans Road	
Divospital of hours at inversal to y filled by		4 Homicide determined (Specify) Single Fa	<del></del>		
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred		
To To con	Mec	and manner stated.  296. Signature and title of certifier	29c. License number	29d Date signed (Mi	onth, Day, Year)
	1	( al weell	O.C.M.E.	February 12, 20	07
(	[ (	30. Name and address of person who completed cause of death (Ite		201	
206		Laron Locke MD. Assistant Medical Examinel		201	
S Regis	tate	FFR 1 6 / IIII Diane	the space		

DHMH 17 Rev 1/2001

Registrar

07-01282	

Thomas Warnick, Jr.

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State of Maryland /	Department of H	Health and N	Mental Hygiene

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		1- For State Registrar		Ce	rtificate of	Death		F	Reg. No.	
Physicia		Decedent's Name (First, Midd	lle,Last)					2. Date of De	ath	3. Time of Death
dical Exami		THOMAS RIC	HARD WAT	RNICK.	JR.			Month February	Day Yea 15, 2007	2135 hrs
		4a. Facility Name (if not institution Civista Hospital				b. City, Town, or L LaPlata	ocation of Dea	ath	4c. County o	of Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24H		irth (MM/DD/YYYY	9. Birthplace (State or Foreign いたらで
Director		216-70-8489 Usual Residence of Decedent	1XM 2F	5	O Yrs.	Months Days	Hours M	DEC.3	0,1956	Foreign WEST CountryVIRGINIA
d now any		10a. State 10b. County	ARLES		ALDORF	on				10d. Inside City Limits  1 Yes 2 XNo
arylan 8a-f sl at one	×	10e. Street and Number	AKDED.	1 44	ADDORT	10f. Zip Code	-	- T	10g. Citizen of Wh	at Country?
5-0036 led within 72 hours after death with the Maryland bygeine other than "natural", or items 23a or 28a-f show a the Medical Examiner must be notified at once.	_	2454 PIMILICO				2060			U.S.A	
eath wit items 2 ust be n	Funeral	11. Marital Status 1 Never Married 2 N	larried Armed Fo	edent Ever in U proes? 2 X No		s Decedent of Hisp es, specify Cuban,			o- 14. Race White	- American Indian, Black, e, etc.
after de	by Fi		or Dates:	ır		Yes 2 X No				WHITE
136  Thin 72 hours after than "natural", edical Examiner.		<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>				t's Usual Occupations  ost of working life. I			16b, Kind of Bus	siness/industry
vithin 7 ene er than	Completed	11			SERVI	CE ADVI				RALD AUTO MA
2 21215-0036 hould be filed within 72 hours aftend Mental Hygiene is marked other than "natural", streevent, the Medical Examiner	Be	17. Father's Name (First, Middle THOMAS RICHA	ARD WARN	ICK, S		1	KATHLE	EEN DOL		IEBREAKER
	To	19a. Informant's Name/Relations		C DAIIC		· ·			imber, City or Towr	n, State, Zip Code)  LLE, MD 20637
ages I and 2 shount of Health and I is If item 27 is other traumatic		20a. Method of Disposition		20b.		ition (Name of cem		Date		City or Town, State
<b>—</b> 6° 77 <b>—</b> 1		1 X Burial 2 Crematio 4 Donation 5 Other S		TRIN	ITY ME	MORIAL (	GDN <b>\$</b> 2	2-22-07	WALDOR	RF, MARYLAND
Baltir permit. E Departme Importal		21. Signature of Funeral Service	*	(MO	04/19 22. N R	lame and Address of AYMOND	of Facility FUNERA	AL SERV	ICE, P.	Α.
Physician	-	23a. Part I. Enter the disease, o	r complications that c	aused the death	h. Do not enter th	A PLATA ne mode of dying, s	MARY uch as cardiac	Correspiratory ar	0646 rest, shock, or hea	art Approximate Interval Between Onset and
/Medical		failure. List only one cause Immediate Cause (Final disease	e a Hypertensi			ovascular Dise	ease			Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a	consequence	of):					
	iner	if any, leading to immediate cause. Enter Underlying Cause		consequence	of):					
ed 🔻	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):		<del>.</del>			
e be executed ysician and burial - transit		UNPENDED	AMENDED			-		-	-	
ficate by g physics the buns the buns	/Medical	IF FEMALE: 23b. Was decedent pregnant in		outcome of pre	gnancy 2 Fe	tal death 3	Ectopic preg	inancv	23d. Date of Month	delivery Day Year
30x 687 death certifine attending I for use as t	Physiciar	past 12 months?		nant at time of d	le eth	her (Specify)				
D. B. t the de by the ached f	뭅	Part II. Other significant cond	9 UNIKIT		resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
ords, P.C. w requires that is been signed I should be deta	d by							-		Probably 4 V Unknown
cords law requested has been 2 should	Completed							24a Was	psy p	Vere autopsy findings available prior to completion of cause of leath?
tal Recian: The la	Com							1 🗸 Yes		Yes 2 No
ital sician: s certif irector,	B	examiner?	A Day and Marks	Inpatient 2	✓ ER/Outpatient		of Death (Chec	sing Home 5	Residence 6	Other:
of V ing Phys After thi uneral d	12	1 V Yes 2 No 27. Manner of Death	28a. Date		28b. Time of I	njury 28c. Injury	at Work?		how injury occurre	ed
ion trending death. ctor: A	ation	1 V Natural 5 Per 2 Accident Investigation	nding estigation				es 2 No	000	(O) to the second	David Number City
									er or Rural Route Number, City	
Solicide  Solici							use(s) and manner e and place, and d	as stated. lue to the cause(s)		
P, W, F, O	Me	29b. Signature and title of certification	and manner : ier	O	1.0	29c. License				ed (Month, Day, Year)
		tatrici 6	Monica	-Tol	let m	O.C.N	1.E. 		February 1	6, 2007
8		30. Name and address of person Patricia Aronica-Pollo		se of death (Ite ant Medical		111 Penn Str	eet, Baltim	ore, MD 212	01	
S	State		2 2007	gistrar's Signa	ature					
Regis		INAN U	a coor	GENT.	ORIGINA					
CIME COCC	2001				AMIDINA	-				

State of Maryland / Department of Health and Mental Hygiene AMEND#30 Per Phy. 2/22/07 AACO HEALTH DEPT. ON Cartificate of Dooth Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Vea **Physician** 8 2007 5:30AM George Wesley February /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner 7007 Nightingale Terrace Prince George's Lanham If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Dey, Jan 14 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Sociel Security Number Yeer) 1928 **Funeral** Months Days 1**X** M 2□ F Yrs. 79 218-20-5446 Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 ☐ Yes 2 TXNo MarylandPrince George's Lanham Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 7007 Nightingale Terrace 20706 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Affried Folces: 1 XYes 2 □ No If Yes, Give Year or Dates: Korean 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry e filed within 7 el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th 4yrs Policeman Metro Police 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi. h end Mentel H ' le merked oth Otho Wesley Hallie Sisco 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 end 2 ment of Health e 8055 Winstead Manor Lane Lorton, Va. 22079 Yvette Schuler (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Depertment Inportant: If 2-17-07 Sharpton, Md. Aaron UM Church 4 ☐ Donation 5 ☐ Other (Specify) Injury 21. Signature of Funeral Service Licensee Williame Redese of &cilisons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 any 5. Seese may 83 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) Rostate Cancer /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No i Director: A investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License numbe 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 867 tak 5 Francine A. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Higgs 9200 Basil Ct. 200 Basi 9100 COURT LaNG 31. Dete filed (Month, Day, Yeer) Registrar's Signature 32 State FEB 22 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of artificate of		Mental Hy	giene Reg. No.	007	06473
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last	Donal	d Wal	Ker		2. Date of De Month	Pay	Year 07	3. Time of Death 9:46PM
	Examin		4a. Facility Name (If not institution, give 5634 Com	pton L	ane	4b. City, Town,	or Location of Dea	2, MD		inty of Death	11
*	Funeral Director		213 40 3373	ex 7. Ag	ge (In yrs. last birthday 59 Yrs.	Months Day			th 19.1 <sup>4</sup> 934)7	9. Birth	place (State or Foreign ntry)Wash. DC
	show	'n	Usual Residence of Decedent           10a. State         10b. County           MD         Carrol		10c. City, Town or L						10d. Inside City Limits 1 ☐ Yes 25 ☐ No
	with the h	Direct	10e. Street and Number 5634 Compton Lane		Bitter	10f. Zip Code 217	84		10g. Citizen	of What Cou USA	ntry?
336	ges 1 and 2 should be filed within 72 hours atter death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show or other traumatic event, the Madical Examinar must be natilised at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Types 2 If Yes, Give Year or Dates:	?	Was Decedent of If Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No orto Rican, etc.)		Race - Ameri Black, White, ecity: Whi	etc.
Maryland 21215-0036	d within 72 hor giene. ir then "natura ire Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		life.	e during most of w ed)	of working 16b. Kind of Business/  Law Enfor				
/land	2 should be filed v and Mental Hygie Is marked other raumatic event, II.	To Be C	17. Father's Name (First, Middle, Last) George William Wa					ame (First, Middle Ruth Wa		name)	
	and 2 sho laith and 1 n 27 is ma er trauma		19a. Informant's Name/Relationship ( Donald L. Walker,					Rural Route Numb ersburg,			o Code)
Baltimore,	Pages 1. nent of He ant: If Iten ary or oth		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disp cometery, cre MD Vet. (	osition (Name of ematory or other pi Cemetery	2/1	Date 6/07		on · City or To enham,	
Balt	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Licen	See Self	_ MOO945		chols Fu	neral Hor ata, Md.	_		
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each I	d the death. Do not end ine.	nter the mode of dy	ring, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	Certificate be executed diding physician and itse as the burial-transit	edical Examiner	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):						
.O. Box 6	the death certif y the attending ched for use a:	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnan	су		23d.	Date of deliver	ery Day Year
rds, P	es De de	þ	Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying cause g	iven in Part I.		obacco use c Yes 2□No	- 4	he cause of death?
of Vital Records,	The law ate has b page 2 si	Completed							autopsy prior to completion of cause of death?		
on of Vita	Attending Phyaician: Th r daath. ector: After this certificate by tha funeral director, pag	ıtlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  Natural 5 Pending investigation	Hospital: 1  Inpati 28a. Date of Inj	ury 28b. Time	of 28c. inj	ther: 4 🗆 Nursing	eath (Check only of Home 5 Resident Res	dence 6	Other (Specificurred	W Hospice
Division	al or Attendi after daath. I Director: A d in by tha f	ertification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home, farm, s tc. (Specify)	treet, factory, office	3	28f. Location (. City or To		imber or Rura	al Route Number,
	To the Hospital or Attent within 24 hours after daatl To the Funeral Director: completely filled in by tha	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, dea of examination and/or i ated.	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	manner as s ce, and due to	tated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	M	M		11218		29d. Date sig	1. 1	
1	B1691		30. Mame and address of person wind Chan bs M. Ha	ompleted cause of	death (Item 23a) (Type MD 390	Print)	Paven B	Ivol B	etim.	re m	07
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6	32. Figist	rar's Signature	back		·/-	· · · · · · · · · · · · · · · · · · ·		

3. Time of Death

3:40 PM

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 Yes 2 No

1-	For Stete Registrar
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1. Decedent's Name (First, Middle, Last)

Physician

Certificate of Death

			Reg.	No.	
2.	Date	of	Death		

Day

2007

Talbot

Black, White, etc.

Texas

Lillie Blanche Feb 20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton

H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Name | Days | Hours | Min. | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name | Name Genesis HealthCare -The Pines Easton 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 95 452-09-4946 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ehow MD Talbot Easton Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Item 27 ie marked other than "neturel", or Iteme 23a or other treumatic event, the Mudical Examinar must be 610 Dutchman's Lane 21601 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married imore, Maryland 21215-0036 1 ☐ Yes 🙎 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Home Furnishings Elementary/Secondary (0-12) College (1-4or 5+) Heelth and Mental Hygiene. Interior Decorator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be William Osbourne Hall Daisy Trahan ٩ Blanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortant: If Item 27 is Sharon L. Hayden/Granddaughter 35706 Poplar Neck Road, Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition rtment of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cem. 02/24/07 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Balti 22. Name and Address of FacilityFramptom Funeral Home, P.A. permit. 21. Signature of Funeral Service Licenses Deper Impo Muhael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Warner

Approximate Interval Between Onset and Death days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No

9 Unknown

in the past 12 months?

Immediate Cause (Final

resulting in death)

IF FEMALE

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

Due to (or as a consequence of):

Due to (or as a consequence of)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Dav

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2[] No

25. Was case referred to edical examiner? 1 Yes 2 7No 27. Manner of Death

1º Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be

determined

2 ER/Outpatient 1 🗌 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

I-VENUE

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) DICHILD

SANCHICZ MD 508

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB

ragall 1

State Registrar

**Physician** 

Examiner

/Medical

ettending physicien and for use es the burial-transit

been signed by the should be detached

has pege 2

certificete

this After thi

within 24 hours after death To the Funerel Director; / completely filled in by the f

director

The law requires thet the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physicien:

To the !

death.

Examine

Physician/Medical

2

Completed

Be

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Certification:

Medicai

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 805PM 16, 2067 4c. County of Death Geneva Lord Waldis ebruar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Memoria albo If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 🙀 F Director 217-36-1253 90 Sept. 30,1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show treumatic event, the Medical Examinar must be notified at Director MD Caroline Federalsburg 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5770 Jester Road 21632 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry s 1 end 2 should be filed within if Health and Mental Hygiene. Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Teller/Bookkeeper Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Lord Edith Lord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Jack Waldis/Spouse 5770 Jester Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of I Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State Concord Cemetery 02/22/07 4 □ Donation 5 □ Other (Specify) Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ementia Physician 2 heimers 4ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ste has been signed by the a page 2 should be detached to Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2□ No 1 🗌 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 FR/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending death. To the Hospital or Attendition within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0053815 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Denton, MD Pulimond M. Korah MD 510 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2209 02 3 John F. Whitley, Jr. 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Wianio sbure Teninsula egional Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 216-14-9614 83 Director Aug. 11, 1923 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 □Yes 217No Director DE Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 36659 Robin Hood Road 19940 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items 11. Marital Status Black, White, etc. 1⊠ Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John F. Whitley, Sr. Grace F. Warback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36695 Robin Hood Road Delmar, DE 19940 Alan Whitley (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 02-15-2007 | Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 East Grove Street Delmar, DE 23a. Part1. Ent' r the di lease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart future. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cau > (F) al disease or condition resulting in death) momon 3 Mray **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ndMI 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 6 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (2) 17 W 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 24 hours after death 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-25036 9

Registrar DHMH 17 Rev 1/2001

State

**ORIGINAL** 

SHORE DRIVE SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 H- R. H DM. 61 H E ATTER N

2007

614

32. Registrar's Signature

H-R

FEB 16

31. Date filed (Month, Day, Year)

Records, To the Hospital or Attending Physician: of Vital Division

prior to completion of cause of 26 Place of Death (Check only one) 25. Was case referred to medical funeral director. Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other Scene 2 ER/Outpatient 3 Inpatient this No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death Certification FOUND 1 X Natural 1 Yes 2 No 5 Pending the Feb 24, 2007 1030 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm street, factory, office building, etc. 3 Suicide 6 Could not be determined 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d Date signed (Month, Day, Year)

Death

Year

Feb. 25, 2007

WI Oloh 30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

31. Date filed (Month, Day Year) State Registrar

29b. Signature and title of certifier

32 Registrar's Signature A POPULO

O.C.M.E.

y 28'			For State Registrar	State of Mary	land	-	rtment of H tificate of L		Mental Hy	ygien Reg. N	200	7 0	6478
4	Physicia		1. Decedent's Name (First, Middle, La. A VIS AT	ARIORI					2. Date of D FEBRU	Peath PRY	ay Ye		Time of Death
	/Medic Examin Funeral Director	4-	5. Social Security Number 6. S	HOSPITAL Tex 7. Age (Ir		TER t birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	10100 -	BUNN  8. Date of B (Month, D	irth 4	BAZT  9.	eath IND (	State or Foreign
	70		Usual Residence of Decedent	1.0	o City 7	Fown or Loc	agtion						side City Limits
	faryla show	ō	10a. State 10b. County  MD Baltin				stown						Yes 2∐No
	the N 28a-f notifie	rect	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What	Country?	
	h with 23a ou st be	al Di	3713 Sonava Ro	ad			211	133			Nige	ria	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates;	r in U.S.	1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2【XNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	lo-	14. Race - A Black, V Specify:	merican Ind /hite, etc. Blac	
	72 ho 'natur dical I	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	-	16a. Deced	ent's Usual Occupa kind of work done o OO NOT use retired,	ation furing most of wor	king	16b.	Kind of Busine	ess/Industry	
171	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		lite. L	N/A	)			N/A		
2	e filed Il Hygi other /ent, t	BeC	17. Father's Name (First, Middle, Last	)				18. Mother's Nan	ne (First, Middl	e, Maide	en Surname)		
<u>a</u>	Menta Menta arked atic ev	To E	Afoke Hassan					Sabitu					
<u>6</u>	l 2 sho		19a. Informant's Name/Relationship (				g Address (Street a						
ב ע	1 and Healtl em 27		Kabir Ariori-So		20b. Plac	ce of Dispos	Sonava sition (Name of	1	Randa Date		Location - City		21133 itate
Dalling	Pages ment of ant: If it ury or o		1		cen Kin	-	natory or other plac norial F	i i	26/07	Ra	ndall	stowr	, Md
משו	permit. Departimport any inj		21. Signature of Funeral Service Lice	Narch		$M^2$	arch fd 300 Waba	f West ash Ave	, Balt	imo	re, M	d 21	1215
	Physician /Medical Examiner		23a. P. 11. Ever the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.  a. O O Due to (or as a co	1	Co	er the mode of dying		or respiratory	arrest,			roximate val Between et and Death
,0070	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a co		T Pin							
O. DOX 00	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal d	eath 3	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day	Year
us, г	signed by the det	by	Part II. Other significant conditions	contributing to death but n	ot resulti	ing in the ur	nderlying cause give	en in Part I.			o use contribut 2  No 3  ☐		use of death?
Hecords		Completed							24a. Wa aut per 1∐ Yes	opsy formed?	prior deat	to completi h?	ndings available ion of cause of
VIII	Physician: this certificaral director,	Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Othe	26. Place of Dea					
5	Phys r this eral dir	2	1 ☐ Yes 2 No 27. Mapner of Death	28a. Date of Injury	2	R/Outpatien 8b. Time of	1 3 DOX	4 LI Nursing F	lome 5 Re		6 ☐Other (S	Specify)	
IVISION	To the Hospital or Attending Physic within 24 hours efter death.  To the Funeral Director: After this ce completely filled a by the funeral director.	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	e 28a Place of injuny	- At hom	Injury e, farm, str	M 1□	k? Yes 2 □ No	28f. Location City or T	(Street own, Sta	and Number o	r Rural Rou	te Number,
Hospital of the hours aft Funeral Distribution tely filled in		Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	aminatio	edge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the arred at the time	e cause e, date a	e(s) and manne and place, and	er as stated. due to the o	cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier	PHYSICIA	AN		29c. License	2723		FEB	Punky	24	Year) 200°
	3		30 Name and address of person who are supported by S. A. S.	completed cause of death	Hr	TRIS	Print) NOI	RTH WE	+ Pr	77	ROAT	J W	D 2113
	Sta Regist	ate rar		2007 32. Augistrar's	Jigriald	K A	ranks)						

State of Maryland / Department of Health and Mental Hygiene 06479 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28,200<sup>7</sup>7 **Physician** B. ANSELL 7:30 AM HOWARD February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 2805 Northwind Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month Day, Year)
Dec. 8, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Pennsylvania 1⊠M 2□F 84 218-18-0850 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene. Important: If Item 27 le marked other then "neturel", or Iteme 23a or 28e-f show empt injury or other treumatic event, the Medical Exart front mat be notified at once. Parkville 1 Yes 2 No MD baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 2805 Northwind Road Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Specify: White ☐ Yes 2 X No Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) H.B. Ansell Elementary/Secondary (0-12) College (1-4or 5+) Owner Excavating Contractor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Schultz Louis Ansell ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Northwind Road-Parkville, Maryland 21234 Josephine Ansell-spouse 20b. Place of Disposition (Name of cometery, crematory or other place)
Gardens Of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland 3-3-07 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL AND CREMATION CHAPEL 8800 Harford Road SERVICES Parkville,MD 21234 trolol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2√No 3 ☐ Probably 4 ☐ Unknown OSTEDARTIARITIS 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete 1 Yes 2 No After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes PNo 1 Inpatient 2 EN/Outpatient 3 DOA Certification: To 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospitel or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descriping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and maker as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Chack only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8025 03-01-200 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 1224 Rosedale, InD Quarni 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#19a, perFIT C865, 3/8/07 WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Blackwell Μ. William relo **38** 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE Agnes HOSPITAL If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □XM 2 □ F 69 10 30 37 VA Director 228-48-4349 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County Baltimore 1X Yes 2 No NA Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 2 U.S.A. 21216 1534 Poplar Grove Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: þ Black 3 ☐ Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metacon Company Truck Drive permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, the ones. 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ruth Jones Hammett Blackwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester-sisister Nannie 1534 Poplar Grove Street, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jones Family Cemetery 3/6/07 Kenbridge, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications the fraued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm diate Cause (Final **Physician** dis ase or condition resulting in death) ow min /Medical Due to (or as a consequence of): Examiner Oscnar many years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4⊡Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ne Unhang 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို To the Hospital or Attending Ph within 24 hours are reach. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27541 February 28,2007 · aletna Lega WID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) For y Rd, Baltimous MD-21227 32. Registrar's Signature 31. Date filed (Month, Day, Year) State souls. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death Month MARCEL MARCH NTON ILAM 200 4b. City, Town, of Location of Death 4c. County of Death TIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
771 RKEV (In yrs. last birthday) Days 1 🕱 M 2 🗆 F Vre 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No 10f. Zip Code 10g/Citizen of What Country? ISON STREE Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 16b. Kind of Business/Industry

1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number **Funeral** -08-042 Director Usual Residence of Decedent 10a. State **Wode** r than "natural, or items 23s or 28s-f ahov The Medical Examiner must be notified at Funeral Director 10e. Street and Number 11 Marital Status filed within 72 hours after Never Married 2 ☐ Married Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INEMPLOYED permit. Pages 1 and 2 should be tile.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
any Injury or other traums. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) HERBERT BELLAMVJR, ၉ 10Hn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Junte Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician ymphoblastic YEAY /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ပို 1 🗌 Yes 21 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Sther (Specify) +0501C2 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attanding Physician: Medicai Certification: Diractor: To the Hospital or Att within 24 hours efter do to the Funeral Direct completely filled in by the

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 T Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D24170 29d. Date signed (Month. Day, Year)

50

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospice 838 Eutaw St 31. Date filed MAR 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MARY **Physician** THEODOSIA BOWIE 1, 2007 3:30 A.M MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BLAKEHURST HEALTH CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-30-1912 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1□M XX F 019-36-9623 94 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD. BALTIMORE TOWSON 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 2 any injury or other traumatic event, the Medical Examiner must be reached. 1055 WEST JOPPA ROAD 21204 U. S. A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \triangle \triangle \) Yes \( \triangle \) No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 🏋 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YEARS OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHAPMAN WALTER ELLA VALLIANT ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT R. BOWIE, JR. (SON) 2328 SHEPPERD ROAD, MONKTON, MARYLAND, 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 03-02-2007 TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility 1050 YORK ROAD 20 RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1□ Yes X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: MXNursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No fter death.

Director: A
in by the fi 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral Completely filled XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) MARCH 2, 2007 dress of person who completed cause of death (Item 23a) (Typer Int) W.D. Falls No. #255 - Lutlarville, MD 21093 Versents 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 Registrar

			1 - For State Registrar	State of Man		oartmen e <i>rtificat</i> e				Rag. N	2007	06483
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Julie Lyn Bley							h 2,		5:10A M
	Examin		4a. Facility Name (If not institution, give s 4533 Oak Ridge	e Dr.		St	tree			1	c. County of De Harfor	·d
	Funeral Director		5. Social Security Number 219-60-8388 6. Sex Usual Residence of Decedent	7. Age (I	n yrs. last birthda 53 Yrs.	y) If Under Months	Days	Hours A		h, Day, Year		irthplace (State or Foreign Country) [aryland
	Maryland f ehow	tor	10a. State 10b. County MD Harford		Oc. City, Town or Street							10d. Inside City Limits 1 ☐ Yes 2 ▼No
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36	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f ehow the Madical Exeminar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	or in U.S. 13	I. Was Deced If Yes, spec		panic Origin , Mexican, P Specify:	? (Specify Yes of uerto Rican, etc	or No-	14. Race - Arr Black, Wh SpecifyWh	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show with injury or other traumatic event, the Madical Engineer must be notified at ODGE.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation s completed)  College (1-4or 5+)	(Gir	edent's Usua ve kind of wor DO NOT us	rk done du se retired)	iring most of	working		Kind of Busines	s/Industry ke Treatmen
Maryland 2	uld be filed Aental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) Donald Rollins						Name (First, Mi	iddle, Maide		
, Mary	and 2 sho		19a. Informant's Name/Relationship (Typ. Laura Cochran-		19b. Ma 4533	iling Address Oak	(Street ar Ride	ge Dr	. Stre	umber, City et, M	or Town, State, ID 211	, Zip Code) 5 <b>4</b>
Baltimore,	Pages 1 in nent of He sant: if item		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Evans F	ematory`or of 'unera	ther place 1 H	ome 3,		For		ill, MD
Balt	permit. Depertr importa eny inj		21. Signature of Fineral Service License		F	22. Name an <b>El Air</b>	d Address 3 <b>New</b> r	e of Facility Evans Cort Dr.	s Funeral Forest H	Chapel Hill, M	& Cremet 21050	ion Services
	Physician /Medical Examiner		23a. Part /Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	Chac onsequence of):			, such as car	diac or respirato	ory arrest,		Approximate Interval Between Onset and Death
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and stepe 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							II.	23d. Date of delivery Month Day Year	
	w requires that been signed t should be det	ρ	Part II. Other significant conditions con	ntributing to death but r	not resulting in the	underlying ca	ause giver	n in Part I.				to the cause of death?  Probably 4 Unknown
al Records,	r: The law requicate has been ; pege 2 should	Completed								Was an autopsy performed?	topsy prior to completion of cause of death?	
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1 Yes 25 No H  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpati 28b. Time Injury		8c. Injury	4 🗌 Nursir	Death (Check of pg Home 5 128d. Desc			pecify)
Divisi	al or Atter after dea i Director d in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	- At home, farm, : Specify)	street, factory, office  28f. Location (Street and Number or In City or Town, State)					Rural Route Number,		
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of r ner: On the basis of ex and manner stated	amination and/or	ath occurred investigation,	at the time in my opi	a, date and p nion, death o	lace, and due to occurred at the t	the cause(s ime, date an	s) and manner and du	as stated. ue to the cause(s)
)	To the To the comple	Σ	29b. Signature and title of certifier	era L	ring !	1.D. 290	License	number 787	3	29d. Da	ate signed (Mon	nth, Day, Year) -12-667
	13		30. Name and address of person who come the state of the	mpleted cause of deat	h (Item 23a) (Typ	e, Print)	lian	ks 97	1. Too	uson	MD	21204
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 0 5 200		Signature	market )						

Print in Black Indelible Ink. Ensure All Copies Are Legible. Maryland / Department of Health and Mental Hygiene

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Vernon Lamont Carter	State of Maryland / De

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		- For State Registrar			Certi	ficate of	Death				Reg No	6- U	10/	U 0	40.
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Division of Vital Records, pital or Attending Physician: The law requirement death.  erall Director: After this certificate has been sifilled in by the funeral director, page 2 should be.	틥	doto	id not be		•			0.	1	or Town	State)	treet Ralf	timore, MD	1	
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	one) 2 Medical Exa	and ma	basis of exar anner stated	mnation and	noi irivestigati				are arrie, da					
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_ \	-	30. Name and address of person	who complete	ed lause of d	eath (Item ?	3a)		<del></del>							
3		Theodore M. King, Jr		ssistant M			111 Penn 9	Street Ba	altimore	MD 212	01				
				32. Registrar											
Sta Regist	ate	31. Date filed (Month, Day, Year)	5 2007	Jz. Kaustial	s orginature	y la	selle?								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Catherine Ann Chilcoat 0025 М 2007 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tal Havre us Grace

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Country) | Months | Days | Hours | Min. | Jan. 28, 1939 | Massachusetts Harford Memorial Hospital 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖾 F Director 217-38-7344 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo Conowingo 1 ☐ Yes 2 X No Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2 Grace Ann Drive 21918 U. S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: ö 1 ☐ Yes 2 No þ Specify 3 Widowed 4 Divorced White Completed th and Mental Hygiene.
7 is marked other then "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) 10th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Wilson Mary Wisnowski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 l other tre Jack W. Chilcoat (Husband) 2 Grace Ann Drive, Conowingo, Maryland 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If its
any injury or oti 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/03/2007 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam Due to (or as a consequence of) Physician/Medical signed by the attending the detached for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1∐ Yes 1 ☐ Yes 2 ☐ No 25 Be 25. Was case referred to medical 26. Place of Death Check only one 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medicai Certification: To 1 🗌 Yes 27. Manner of eath 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation after death To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauca(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day,

MAR 0

3a) (Type, Print)

32 Registrar's Signature

2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Ellen C. Carter 2 27 2007 9:04p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

House House 24 Hrs. Future Care-Homewood If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**1X Days Months 219-20-8449 Director 85 N.Y. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 3506 Copley Road 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 2 XXWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than Penn Station N/AWaitress filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l and 2 should be fil lealth and Mental H m 27 is marked oth Be David Bryant Martha Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.3 Department of Health at Important: If item 27 is any injury or other trau Charles Sheppard-nephew 5406 Lewellen Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 3/5/2007 Baltimore Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST B Q 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for as a consequence of -transit the death certificate be executed and Due to (or as a consequence of) physician a the burial-t Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 21 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation death Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide lor / vo the H.c. within 24 hours vare Funeral Dicertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of

2007

MAR 05

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Greene Tree Bl 21208

(Item 23a) (Type, Print)

32. Registrar's Sign

			1 - For State Registrar	tate of Maryla		artment of H			21111	06488
			Registrar  1. Decedent's Name (First, Middle, Last)	1.00	Cei	Tillicate Of L	Jeani	2 Date of Death	. No.	3. Time of Death
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) .	/Medic		4a. Facility Name (If not institution, give stree	t and number)			Location of Death	7 027 4 47 9	4c. County of Deatl	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. (ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	nplace (State or Foreign
	Director		000000	341	Yrs.			4/22/0	RG MA	RYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary 1 ehe	ō	MD Harford	1	1.1h	Hefora	1			1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number		- W/1	10f. Zip Code		109	. Citizen of What Co	untry?
	th with	Funeral Director	4107 Mclabb	Rd.		21	160		115	A
	-ms	ner	11. Marital Status 12. V	Vas Decedent Ever in	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	city Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or it	by FL	1 Never Married 2 Married 1	☐ Yes 2 No f Yes, Give		1 ☐ Yes 2 KNo	Specify:	,	Specify:	h :1 =
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "naturel", or items 23e or 28e-f ehow event, if a Medical Examination must be notified at	ed b	15. Decedent's Educatio	/ear or Dates:	16a Dece	dent's Usual Occupa	ition	16	b. Kind of Business/l	Mr.
7	n na	Completed	(Specify only highest grade cor	npleted)	(Give	kind of work done d DO NOT use retired)	luring most of workii	ng	O. KING OF BUSINESSY	ndustry
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Bea	utici	an		asmoto	logu
g	al Hyd	BeC	17. Father's Name (First, Middle, Last)	A 11.			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>V</u>	Ment Ment Ment Ment Ment Ment Ment Ment	10	Granville Mc	Callist	er		Mary 1	6thel	Montag	mery
Ja	2 sh and ie m		19a. Informant's Name/Relationship (Type, F	²rint)	19b. Mailir	ng Address (Street a	and Number or Rura	l Route Number, C	city or Town, State, Z	ip Code)
	1 and dealth om 27 ther t		20a. Method of Disposition	201	o. Place of Dispo	I MCILA	bb Kd	White 20	tord m	D 21160
و	ages if ite		1 Burial 2 ☐ Cremation 3 ☐ Remo		cemetery, cren	natory or other place	<b>为</b> し	2/2/	c. Location - City or I	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		OLHICIM	emorial (	January S	3/2/01	Deltic	MU
Ba	Dermi Depa impo any i		Kinchelly 1	Vilatara	-	Name and Address 3 New Cans Fund	Sport Dis	Forest 17	III, MDZ	
			23a. Part . Enter the disease or complicated shock, or heart failure. List only one ba	ns that caused the de	eath. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arrest	uention Se	Approximate
	Physician		Immediate Cause (Final	7	. 1 ~	thous	5			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		ririve	1	4.		
ı	Examiner		Sequentially list conditions, b	Periphe	eral	VASCU	lar D	sease		
	g 🖟 👼	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as) a cons	sequence of):					
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8760	cate be executed physician and sthe burial-transit	dicai E		`	,,					
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о. В	deat death	sicia	1 Yes 2 X No	Pregnant at time o		Other (specify)			Month	Day Year
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a	Physician: The la r this certificete her ral director, page 2	ပိ	OF Was seen referred to modical					1 Yes 2		2
5	Physician: r this certifice ral director, p	003	25. Was case referred to medical examiner?  1 Yes 2 No	tal: 1  Inpatient 2	☐ ER/Outpatien	Othe	r: Nursing Hos		e 6 □Other (Spec	
Division of Vital Records,	g Phy er thii	n: To	27. Manuar of Death 28	Ba. Date of Injury (Month, Day Year)	28b. Time of			8d. Describe how		(y)
0	ath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monar, Day 16ar)	) Injury		r ′es 2 □No			
Σ	r Atte	Certification:	3 Suicide 6 Could not be determined 28	Be. Place of Injury - At building, etc. (Spe	t home, farm, str	eet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rui State)	al Route Number.
	urs af									
	To the Hospitei or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physicial (Check only one)	<ul> <li>To the best of my k</li> <li>On the basis of examinand manner stated.</li> </ul>	knowledge, death ination and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the caus and at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	Ind mariner stated.		29c. License	number	29d.	Date signed (Month,	Dav. Year)
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	h		30. Name and address of person who complete	ited cause of death (If	tem 23a) (Type.	Print) 8 L	1189	TE	chram	20, 200 t
			Manuel Wash	i / MP		\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	elech	Maryl	and	21001
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- 1	Registr	ar	MAR 0 5 200	1 Maria	15 A	medil				

			1 - State Amend #5 Per F	State of Maryland	Departure Depart	artment of H	lealth and <i>Death</i>	Mental Hy	giene Reg. No. 0 0	7 06489
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ANNIE D. CAN	ETER				2. Date of De Month		Year 7:47 P M
	Examir		4a. Facility Name (If, not institution, give : \$610 HICKORY		21	4b. City, Town, o	r Location of Dear		4c. County o	
	Funeral Director		213263838	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Year) 1,1932	9. Birthplace (State or Foreign Country)
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	with the I	Funeral Director	10e. Street and Number 8610 HCKORY T		7 (7) 1	10f. Zip Code	236		10g. Citizen of Wi	
980	72 hours after death with the Maryland netural', or Itams 23a or 28a-f show dical Examiner roust be notified at	by		12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of Hilf Yes, specify Cuba	lispanic Origin? (San, Mexican, Puer	Specify Yes or No to Rican, etc.)		- American Indian, , White, etc. BIACK
21215-0036	within ane. than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d) 4 R V			PWMGNT
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	nd 2 s lith ar 27 is r trau		19a. Informant's Name/Relationship (Ty, MAYZELIA CONLE	sy-POA.	5908	ng Address (Street	VEN BIV			
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition  1  Burial 2  Cremation 3  R  4  Donation 5  Other (Specify)	GAR	RISON T	esition (Name of matory or other place)  OREST VE	TERAN	Date 06,2007	OWINGS	MILLS, MD
Bal	permit. Departr Imports any inji		21. Signature Funeral Service License	Hacket S.	8	14 UPSH	UR ST. M	I.W. WA	ASHINGTO	ERAL CHAPEL ON, DC 20011
	Physician /	0	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	. Mutwot	tic				rrest,	Approximate Interval Between Onset and Death  Mo.
8760,	Examiner cian and ciansit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate must find the first line cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence)  Due to (or as a consequence)	ence of):					
.O. Box 6	death certifi e attending d for use as	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	-
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Division	7 7 7 7	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	edge, death	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (	
			your other	<u>·</u>		04	0850		March	1,2007
1			30. Name and address of person who co	OTTAVIANO	23a) (Туре, М.)	Print) 9103 F	rmklin	Square B	r. Baltu	1,2007 me MD 21237
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 5 20	32. Rastrar's Signatu	ILE TO THE PARTY OF THE PARTY O	prot		ū		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #4c Per State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar &10b Per Fh Certificate of Death Reg. No. &10b Per Fh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician March 2, Anna Demetro 9:20pm /Medical 4c. County of DeaMontgonery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10408 Sweetbriar Parkway Sliver Spring Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 7, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 TT **Funeral** Months 350-09-4134 87 1 □ M 2 X F TT. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County Montgomery 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Prince George's Silver Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 20903 10408 Sweetbriar Parkway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. White Specify: Completed by 3 Widowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teletyper ElectricalManufacturer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Semkiw Maria Shemkiw ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10408 Sweetbriar Parkway, Silver Spring, MD 20903 Mary Bergman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Nicholas Cemetery 03/08/2007 Chicago, IL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atharosciarotic Corprovascular Diseasce Physician /Medical Due to (or as a consequence of): **Examiner** partanscor Sayus filling life co. notice, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9∏I Inknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Divarticulosis 1 TYes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed' 1□ Yes 2 🗔 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.
neral Director: A 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my pointing death. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. 29d. Date signed (Month, Day, Year) MARCH 3, 2007

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State 31. Date filed Registrar

e filed (Month, Day, Year) 22. Registrar's Si

5411 W. Cedar Lane 82. Registrar's Signature

DHMH 17 Rev 1/2001

#2024 Bathuson, Md 20814

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Feb 28, George A. Dewees 13:10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. Min. Bay, Year)
Months Days Hours Min. (Month, Day, Year)
June 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 579 16 7718 85 **Director** 1921 Indiana Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits orlant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Machael Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1410 Rich Hill Drive 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status XXYes 2 No WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White à 3\\ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Electronic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked o Howard Dewees Elma Scarlet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig T. Dewees (Son) 1410 Rich Hill Drive, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar 3, 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 X Yurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Forestville, MD Eiphany Epis Church Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee any in Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) ARTERIO Scleratic heart Disease Physician /Medical Examiner OBSTRUCTIVE Lung Discome CHRMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical S for use IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 Who 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Vinpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 4 hours after death. investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 11701 LIVING 1h Road Fort WASHington um TANNER MY William 1 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 2 **Physician** 2007 7:15 pm Helen E. Dorsett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Oak Crest Care Center</u> Parkville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3 / 22 / 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔽 F 79 Yrs. Director 577-42-4306 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Parkville 1 Yes No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 21234 USA 8800 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes XXNo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Schools Educator/ Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Elizabeth Jeffery Telfair Bowie Dorsett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8355 Glenmar Rd. Ellicott City, MD 21043 Department of Health an Important: If item 27 is any injury or other trau Robert MacKenzie Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel – Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State Forest Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. And Cremation Services Parkville, MD 1234 22. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End stage zheimers /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dué to (or as a consequence of): Examine signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> atrial fibrillation, diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 4No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Mannef of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

or Vital Records, ivision

To the Hospital within 24 hours at To the Funeral D

Medical

31. Date filed (Month, Day, Year) State Registrar

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

MAR 0 5 2007

5 Pending investigation

6 Could not be determined

and manner stated.

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Parkville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800 walther Blud 32. Registrar's Signature

MARKE !

07-01606	
Yesmeen Day	

esmeen Day	State of Maryland / Department of Health at 1-For State Registrar  State of Maryland / Department of Health at Certificate of Death	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  Vesmeen H. Dov	Reg. No.  2. Date of Death  Month Day February 27, 2007  Reg. No.  3. Time of Death 1025 hrs
	4a. Facility Name (if not institution, give street and number)  Upper Cheseapeake Medical Center  4b. City, Town, or Bel Air	or Location of Death  4c. County of Death  Harford
Funeral Director	//12	ear If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) A a Ka
or items 23a or 28a-f show any must be notified at once.	10a. State 10b. County 10c. City, Town or Location 10e. Street and Number 10f. Zip Code 375   Beckles (Rd P1) Roy 122	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA Hispanic Origin? ( Specify Yes or No- pan, Mexican, Puerto Rican, etc.) 11d. Race - American Indian, Black, White, etc.
36 in 72 hours afte han "natural", lical Examiner pleted by	3   Widowed   4   Divorced   If Yes, Give Year   1   Yes   2   No.	pation (Give kind of work done 16b. Kind of Business/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than " injury or other traumatic event, the Medical To Be Comple	Richard Henry Healy	eet and Number or Rural Route Number, City or Town, State, Zip Code) 2/034-0/22  Ley No. P.O. Box 122 Jacking ton MD  semeter, Date 20c. Location - City or Town State  Hir Pel- 3/1/07 Fore St Hill, MD
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying failure. List only one cause or nearly line.  Immediate Cause First disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Undease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	eral Chapet Cromation Services - Bel Ara
0, : be execut sician and ourial - tra	d.  X AMENDED #7 perFH, C868, 6/1/07, WS #23a, 27, 28a-f, perME, g865, 3/20/0  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions	23d. Date of delivery  Month Day Year  e given in Part I.  23d. Date of delivery  Month Day Year
of Vital Records, P ng Physician: The law requires the fact this certificate has been signs meral director, page 2 should be d n: To Be Completed b	22 Die	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? performed? 1 ✓ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
Division pital or Attendiours after death ceral Director: A filled in by the fu	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA  27. Manner of Death 1 Natural 5 Pending Investigation 3 X Suicide 6 Could not be determined (Specify) home	other of Death (Check only one)  Other Other Other Other Other  John Garage State Of Check only one)  Other Other Other Other  John Garage State Other  Subject ingested drug  Subject ingested drug  28f. Location (Street and Number or Rural Route Number, City or Town, State)  3751 Bertzley Rd. Darlington, MD
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, done)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.  29b/ Signature and title of certifier	date and place, and due to the cause(s) and manner as stated on, death occurred at the time, date and place, and due to the cause(s)
		29d. Date signed (Month, Day, Year)  February 28, 2007
	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201

ed by the ettending physicien and detached for use as the burial-transit signed by 99 been page 2 s this certificete To the Hospital or Attending Physicien: After this certific funeral director, death. Director: / within 24 hours a

**Physician** 

/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Physician/Medical

9

Completed

Be

2

Certification:

Medical

4 Homicide

(Check only one)

29b. SignetUse and title of certifier.

Michael 31. Date filed (Month, Day, Year) 007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maratin

29a. Certifie

32

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if flem 27 is marked other then "natural", or flems 27 s.marked other then "natural", or flems 27 s.marked other then and then approximately or other treumatic event.

State Registrar

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, MD

07-01647 Robert Ewing

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		ertificate d	of Death			Reg. N	o.	1 1 10 0 7 2
Physici Modical Exam		1. Decedent's Name (First, Middle, L Robert V. Ewi					Mon	of Death th Day	/ Year	3. Time of Death
		4a. Facility Name (if not institution,			4b. City, Tow	n, or Location		ch 1, 2007	7 4c County of De	0545 hrs
		Harbor Hospital Center			Baltimo	е			n/a	
Funeral Director		212-42-8245	Sex 7. Age (In yrs <b>X</b> M 2 F <b>64</b>	s. last birthday) Y	If Under 1 Months	Year If Under		te of Birth (MI b 26,	Eα	Birthplace (State or preign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County	I10c. C	ity, Town or Loca	ation					10d. Inside City Limits
ryland a-f show a t once.	ctor	Maryland Baltin		Balti	more	-				1 Yes 2X No
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tam: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Marri 3 Widowed 4 Divorce	1 X Yes 2 No	1 If	Yes, specify C	uban, Mexican  No specify:	gin? ( Specify Ye , Puerto Rican, e	etc.)	White, etc	merican Indian, Black, c. White
036 ithin 72 hours ne. r than "natur Iedical Exam	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)  1	during i	ent's Usual Occ nost of working Ceman	upation (Give life. DO NOT	kind of work done use retired)		Kind of Busine	·
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Baltimore, ME semit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum		20a. Method of Disposition  1 Burial 2 X Cremation	Removal from State	p. Place of Dispo crematory or o	sition (Name o ther place)	f cemetery,	Date	20c	Location - City	or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite	F	4 Donation 5 Other Speci 21. Signature of Funecal Service Lic		ayview (	Cremato Name and Add	ry Iress of Facility	3/6/07 Hubban	Ba d Fune	ltimore	e, Maryland me, Inc.
		Julah O	Line	41	107 Wil	kens Av	<i>r</i> enue. B	altimo	ore. Mar	ryland 21229
Physician _//ledical		23a Party. Enter the disease, or cor failure. List only one cause on Immediate Cause (Final disease	nplications that caused the dea each line. aHypertensive_ar					ory arrest, sh	lock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence		n cardio	vasculai	ursease			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/IV	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome of pre	2 Fe	etal death ther (Specify)	3 Ectopic	pregnancy	23	d. Date of deliv	ery Day Year
O. B at the d 1 by the tached		Part II. Other significant conditions	-	resulting in the	underlying cau	se given in Par	t I. 23e.	. Did tobacco	use contribute	to the cause of death?
S, P. uires th n signed Id be de	ed by	Diabetes mellitus:	renal failure				1[	Yes 2	No 3 Pr	robably 4 Unknown
Cord	Completed	<del></del>						Was an autopsy performed?		autopsy findings available o completion of cause of ?
l Re n: The tificate or, pag		25. Was case referred to medical			26 Pi	ace of Death (	1 Check only one)	Yes 2 N	1 🗸	Yes 2 No
Vita tysicia this cer	ŏ	examiner? 1 ✓ Yes 2 No	Hospital: 1 / Inpatient 2	ER/Outpatien		Other <sub>4</sub>	Nursing Home	5 Reside	ence 6 Oth	ner:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	tion: T	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of	· ·   _	njury at Work?		scribe how inj	ury occurred	
Divisior Hospital or Attenc 24 hours after death Funeral Director:	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 2Be. Place of Injury - At	home, farm, stre	et, factory, offic	ce building, etc		ation (Street a own, State)	and Number or F	Rural Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled	ल	29a. Certifier 1 Certifying Physi	cian: To the best of my knowle er:On the basis of examination and manner stated.	dge, death occu and/or investiga	rred at the time	, date and place	ce, and due to the urred at the time	e cause(s) ar , date and pla	nd manner as sta	ated. the cause(s)
F 3 F 3	Me	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d	Date signed (M	fonth, Day, Year)
		Jan.	Te if Mr		0.	C.M.E.		Mai	rch 2, 2007	
4.		<ol> <li>Name and address of person who Tasha Greenberg MD.</li> </ol>		,	Donn Street	t Baltima-	- MD 04004			
ψ St	ate <sup>5</sup>	B1. Date filed (Month, Day, Year)	Assistant Medical Exar			et, Baitimor	e, MD 21201			
Regist		MAR a 5 200	7 Registrar s Signa	ture						

P.O. Box 68760. Division or Vital Records,

death certificate be executed the burial-tran as attending | use ed by the signed by has certificate Attending Physician: the Hospital or Attending F hin 24 hours after death. the Funeral Director: After completely filled in by the To the Hospital within 24 hours at To the Funeral E

with the Maryland

Baltimore, Maryland 21215-0036

23a or 28a-f show

must be notified at

29a. Certifier Medical (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of c

MAD

29c. License number

Greene Tree Rd 21208

30. Name and add of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year) MAR 05

State

Registrar

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Physicia	_	Registrar 1. Decedent's Name (First, Middle,La				2. Date of Deat	g. No	3. Time of Death
Medical Exami		VIC GIO	310 ROV	FENNE	R	Month February 2	Day Year 7, 2007	0340 hrs
		4a. Facility Name (if not institution, g	ve street and number)		, Town, or Location of Dear	th	4c. County of Dea	4
		Johns Hopkins Hospital	17.4		imore		N,	. ,
Funeral Director		5. Social Security Number 6. S		i 7 Mor	nder 1 Year   If Under 24Hi hths   Days   Hours   Mi	_	Fore	
	ł	Usual Residence of Decedent	X M 2 F	Yrs.		DEC. 1	<u>8,1989  °</u>	OUNTRY MARY LAND
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Maryla 28a-f	Director	10e. Street and Number		101. 2	lip Code	10	g. Citizen of What Cou	untry?
Baltimore, MD 21215-0036  Searni. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	₫	1019 ARLI	NGTON AVE	NUE	2121	7	USA	
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er dea			1 Yes 2 No		2 No specify:		0	1 001/
hours afte natural",	g.	15. Decedent's Education (Specify	or Dates:		al Occupation (Give kind of	work done	Specify: 16b. Kind of Business	/Industry
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5-0036 led within 72 Hygiene other than	Completed	//THGRADE		STUL	DENT		HIGHC	SCHOOL
filed v Hygi d other		17. Father's Name (First, Middle, Las	t)	· 1 . 1 = 0	18.Mother's Nam	ie (First, Middle, M	aiden Surname)	0.511
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Baltimore, MD 2121 permit. Pages I and 2 should be if Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		DIANE FENNE	, , , , , , , , , , , , , , , , , , ,	1019	4RIINCTO	1) AVE	BATIMAN	PE MA 51217
e, N l and Health item	ľ	20a. Method of Disposition	20b. F	Place of Disposition (N		Date	20c. Location - City o	r Town, State
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Baltir permit. I Departme Importal injury or	ŀ	A Other Specification 5 Other Specification 21. Signature of Funeral Service Lice			nd Address of Facility	Raulali	TP FULLE	PAI HAME
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Box 68760, e death certificate be the attending physicical for use as the burined for use a		IF FEMALE:	23c. If yes, outcome of pregi	nancy			23d. Date of deliver	у
68 certifi nding	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal deat		ancy	Month	Day Year
30x death	ysic	1 Yes 2 No 9 Unknow		other (Sp	pecify)			
O. E at the d by the stachee		Part II. Other significant conditions	contributing to death but not re	esulting in the underlyi	ng cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
F. P.O.	d by					1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
ords  v request been should	Completed	_				24a Was a autops		utopsy findings available completion of cause of
ecc he lav	E					perform 1 <b>V</b> Yes 2		es 2 No
al R	Bec	25. Was case referred to medical			26. Place of Death (Check	only one)		
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach.	2	examiner?  1 Yes 2 No	Hospital: 1 / Inpatient 2	ER/Outpatient 3			Residence 6 Othe	er:
Division of Vital Records, and an artending Physician: The law requires after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	اڃَ	27. Manner of Death  1 Natural 5 Deading	28a. Date of Injury (Month, Day Year) Feb 26, 2007	28b. Time of Injury 1950 hrs	28c. Injury at Work?	28d. Describe he Subject shot	ow injury occurred	
SiOf Attend r death ector: by the	Satic	2 Accident S Pending Investiga	ition		1 Yes 2 No	005.1		
Divis	Certification:	3 Suicide 6 Could no determin		ome, farm, street, facto	iry, οπice building, etc.	or Town, St.	treet and Number of Ri ate) ord Avenue, Baltimo	ural Route Number, City
lospita I hours innera		29a Certifier	cian: To the best of my knowled	ne death occurred at t	he time, date and place, an			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	(Check only	er:On the basis of examination a					
To wit	Me	29b. Signature and title of certifier	and manner stated	2	9c. License number		29d Date signed (Mo	onth, Day, Year)
		Pt	Palor		O.C.M.E.		February 28, 20	07
J.		30. Name and address of person who	completed cause of death (Item	1 23a)				
		Patricia Aronica-Pollak M			Penn Street, Baltimo	re, MD 21201		
	ate	31. Date filed (Month, Day, Year)  MAR 0 5 20	32 Registrar's Signatu	ure Sparker				
Regist	ıısı	MAK U D ZU	UI JESTALIAN SO.	Marie				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

	ian cal	1. Decedent's Name (First, Middle, Last)  MARLENE ROSLYN	FOUNTAIN	2. Date of Death Month Day	Year 2007 01 27 A N
Exami		4a. Facility Name (If not institution, give street and number)  SINAL HOSPITM OF BALTIMORE	4b. City, Town, or Location of Death	4c. (	County of Death N/A
Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	oirthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 9/2/ (Month Day, Year) 09/01/1934	
show ed at		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
a or 28a-f sh	Director	MD BALTIMORE  10e. Street and Number	BALTIMORE 10f. Zip Code	10g Citiz	1 □ Yes 2 💢 No
23a or ust be		16 OLD COURT ROAD #605	21208		USA
'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ★ No  If Yes, Give  Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 No Specify:</li> </ul>		14. Race - American Indian, Black, White, etc.  Specify: WHITE
giene. ir than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of worki     life. DO NOT use retired)	ng 16b. Kin	nd of Business/Industry
Hygiene ther tha nt, the I		12 College (1-407 54)	WAITRESS 18 Mother's Name	RE:	STAURANT
Mental I	To Be	BENJAMIN	SKLAR JEAN	(First, Middle, Maiden S	KAPLAN
Ith and 27 is ma			b. Mailing Address (Street and Number or Rura 16 OLD COURT ROAD #302		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mec once.		20a. Method of Disposition  1 M Burial 2 □ Cremation 3 □ Removal from State	of Disposition (Name of Eery, crematory or other place)	ate 20c. Loc	cation - City or Town, State
artment ortant; injury		4 □ Donation 5 □ Other (Specify) MD VE  21. Signature of Funeral Service Licensee			INGS MILLS, MD
any one	, X	Acath M. little	8900 REISTERSTOWN	ROAD - PIKI	& BROS., INC. ESVILLE, MD 21208
ysician Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	on not enter the mode of dying, such as cardiac of AL INFARCTION	r respiratory arrest,	Approximate Interval Between Onset and Death
			of):		
caminer	_				
	ıminer	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury			
	al Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	o of):		
	g	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause. Einer Underlying Cause)  c. Due to (or as a consequence death)	o of):		
	g	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	e of):	23	3d. Date of delivery Month Day Year
	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	e of):  e of):  th 3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did tobacco us	
is been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	e of):  e of):  th 3 □Ectopic pregnancy 5 □ Other (specify)	23e. Did tobacco us 1  Yes 2	Month Day Year  se contribute to the cause of death?  No 3 Probably 4 Vunknown  24b. Were autopsy findings available prior to completion of cause of death?
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is been signed by the attending physician and 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enher underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions contributing to death but not resulting PERIPHERAL VASCULAR DISEASE  ADRTIC ANEURYSM  25. Was case referred to medical examiner? 1   Yes   2   No   1   1   1   1   1   1   1   1   1	e of):  th 3 □ Ectopic pregnancy 5 □ Other (specify)  in the underlying cause given in Part I.  26. Place of Death  outpatient 3 □ DOA Other: 4 □ Nursing Hon	23e. Did tobacco us  1  Yes 2   24a. Was an autopsy performed? 1 Yes 2 No	Month Day Year  se contribute to the cause of death?  No 3 Probably 4 Dunknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
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is been signed by the attending physician and 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Emer Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	26. Place of Death  Time of Injury M 1 Yes 2 No arm, street, factory, office	23e. Did tobacco us  1	Month Day Year  Se contribute to the cause of death?  No 3 Probably 4 Vunknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 Volo  Other (Specify)  occurred
been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Emer Undertying Cause (Disease or injury that initiated events resulting in death) Last    FFEMALE:	26. Place of Death  Time of Injury M 1 Yes 2 No arm, street, factory, office	23e. Did tobacco us  1	Month Day Year  Se contribute to the cause of death?  No 3 Probably 4 Vunknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 Volo  Other (Specify)  occurred

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death PEBLUARY 25, 2001 **Physician** Green /Medical Melvin 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, If Under 24 Hrs Birthplace (State or Fore Country) **Funeral** 1**反**M 2□F Yrs. 81 Director 07 SC 248-32-5345 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. inside City Lim show Department of Health and Mental Hygiene. Important; if item 23a or 28a-f shov important; if item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at M∏Yes 2∏1 Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21229 U.S.A. Street 711 Mt. Holly Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchant Marine Various Jobs 12 should be filed w h and Mental Hygier Is marked other th 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie Singletary Calvin Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lenox Ave Apt 18B, New York, NY 10039 Pearl Green-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State Garrison Forest Vet 2/5/07 4 □ Donation 5 □ Other (Specify) Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death MYOCAR DIAL INFARCTION **Physician** 40 mino /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) ivision or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by YPERTENSION 1 Yes 2 No 3 Probably 4 Unknow After this certificate has been si funeral director, page 2 should the 24b. Were autopsy findings availal prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS 57 CHARLES

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DOUS 1865

HOSPITAL.

				partment of Health and Nertificate of Death		iene 0 0 7	06500
E	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Yea	3. Time of Death
	/Media		Delma M. Glace		March 2.		12:12 P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
			Edenwald - Stroh Hall  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Towson  If Under 1 Year   If Under 24 Hrs.	0.0-1(8:4)	Baltimor	
	Funeral Director		204-07-6913  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 2	Year)	irthplace (State or Foreign Country) Maryland
	yland Jow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Ba-f s	Director	MD Baltimore Towson				1 ☐ Yes 2 💢 No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What (	Country?
	s 23a	rai	800 Southerly Road	21286		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If tiern 27 is marked other than "natural", or Itams 23a or 28a-f show any njury or other traumatic avant, Ira Madical Examinar must be maillist at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Vhite
Maryland 21215-0036	2 hot		15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Busines	
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7	filed wi Hygien Sthar th	Con		cretary		Food Serv	ice
and	be fill Hall Had off	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		faiden Sumame)	
7	should and Men a marka umatic	ပ	William W. Conn, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Hattie			
Ma	nd 2 si ith an 27 is r		1.11	iling Address <i>(Street and Number or Rur</i> 5 <b>Charles Valley</b> Ct	al Route Number, Δn+ F	City or Town, State,	Zip Code)
ē,	tam 2	13	20a Method of Disposition 20b Place of Dis	position (Name of		Oc. Location - City of	
D E	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State   Cemetery, C	matory or other place) /alley Mem Grdn.	/2007		
Baltimore,	pemit. I Depertm Importal any nju		21. Signative of Funeral Service Liouses	22. Name and Address of Facility Ruc	k Towson	Timonium,	Maryland
ä	Department of the sany of the			1050 York Road, Tow	son. Mar	vland 21	204
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
u	Pnysician	10	Immediate Cause (Final disease or condition	4 (sdomins)	no (19	rover -	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	4	/	8	20007
	LAGITIMICI	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	along mypi	cun		7 days
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury	0 00	0		,
	al-tra	xar	that initiated events resulting in death) Last C				
8760,	cate be executed physician and the burial-transit	dlcal	Cd				
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ds,	signed d be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	III		o the cause of death?
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		င္ပ	25 Was approximated to madical			No 1 □ Yes	s 2 No
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o	문 음글	n: To	27. Manne of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ne 5 ∐ Residen 28d. Describe how	ce 6 Other (Spe	ecify)
Ö	ittending Ph death. ctor: After th the funeral	atlo	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
	i or Attencafter death Director: In by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
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	To tha Hospital or At within 24 hours after of To tha Funeral Diract completely filled in by	edical	29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, a nvestigation, in my opinion, death occurred.	and due to the cau ed at the time, date	ise(s) and manner as e and place, and due	s stated. a to the cause(s)
	To To Corr.	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	
	_		phelan	279769		3/2/0	7
	13			D 516M Ru	(1)	10 1	1 21728
			merceling 1. Hisverne a	D 1600- PU	Way "	4 1701	4 mg
	* Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature				